HOUSE OF COMMONS SESSION 1992–93

HEALTH COMMITTEE

RESPONSIBILITIES OF THE DIRECTOR OF STATISTICS AND THE DIRECTOR OF RESEARCH AND DEVELOPMENT, DEPARTMENT OF HEALTH

MINUTES OF EVIDENCE

Wednesday 21 April 1993

DEPARTMENT OF HEALTH

Mrs R J Butler, Mr R K Willmer, Mr B J Derry and Professor M J Peckham

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MINUTES OF EVIDENCE

TAKEN BEFORE THE HEALTH COMMITTEE

WEDNESDAY 21 APRIL 1993

Members present:

Mrs Marion Roe, in the Chair

Mr Hugh Bayley
Mr James Clappison
Mr David Congdon
Tessa Jowell
Alice Mahon
Mr Roger Sims
Rev Martin Smyth
Mr Michael Trend
Audrey Wise

Examination of Witnesses

MRS R J BUTLER, Director of Statistics, MR R K WILLMER, Chief Statistician, Statistics of Health Services Activities, and MR B J DERRY, Chief Statistician, Finance and Corporate Information Division, NHS Management Executive, Department of Health, examined.

Chairman

1. Good afternoon, ladies and gentlemen. On behalf of the Members of the Health Select Committee, I should like to welcome our first guests this afternoon, Mrs Butler, who is the Director of Statistics at the Department of Health, Mr Willmer, who is the Chief Statistician, Statistics of Health Services Activities, and Mr Derry, who is the Chief Statistician of the Finance and Corporate Information Division of the NHS Management Executive. You are very welcome here this afternoon and I am quite sure we are going to find the answers to the questions we are going to put to you very interesting indeed. I would like to put the first question to the panel before us. I am sure that you have read much comment in the press and heard comment from politicians in the past about the role of statisticians as far as government is concerned. In fact in December there was an article in the *New Scientist* which I think was putting forward certain views which I am sure you would already know about, so the question I would like to put to you is: what changes are being made to the Department's policies about statistics in response to the more open policies advocated by the current head of the Government Statistical Service and also the effect following the Rayner doctrine, which has been followed in the past? Mrs Butler, would you care to start?

(*Mrs Butler*) Thank you. I think you are obviously well aware that the head of the Government Statistical Service, Bill McLennan, has initiated an internal inquiry into gaps in statistics and this was reported in the *Financial Times* a few weeks ago. We have been closely involved in that from the outset. He came to visit us early last year as part of his annual review of government statistics which he undertakes on behalf of the Prime Minister and it was one of the issues he raised with us then and we have discussed it with him since. He has now raised it as a much wider issue and discussed it with all the directors of statistics and he is taking it forward in a series of Government Statistical Service committees to review the gaps in social statistics in particular. We have not as yet identified any gaps in health statistics which are concerning that group, although their work has only very recently been started. I think the most likely issues to arise from that are cross-departmental issues and really until the review is completed we shall not know which ones he is going to attach the most importance to and how he is going to take that forward. In relation to the Rayner doctrine, I think we all suffered from the Rayner doctrine when it was implemented some many years ago and there were cuts in statistics in the Department of Health, as there were in many other places. I think what we have tried to do throughout the period since then is to ensure that we are trying to keep up with the changes which are taking place in health, the changes of interest that the Department has and the changes of interest that the outside world has in health statistics. As you will understand, there is a tremendous range of change going on at the moment. We do our utmost to make a lot of our information available, and I hope the Committee have in front of them a long list of the publications that we regularly produce which indicates the extent to which we do actually make our products widely available to the outside world.

Mr Trend

2. Can you tell us what the conclusions were of the review of the Department's statistics by Touche Ross and what changes are being made in the light of these?

(*Mrs Butler*) I think there is some slight confusion about the role of Touche Ross in that exercise and, if I may, I should perhaps just explain that. Touche Ross were taking part in a much wider review of central returns which was being undertaken as part of one of our information strategies, and I can explain a little more about those later if the Committee would like me to do so, and this was part of the hospital and community health service information strategy. They were asked to undertake a study of the problems that are faced by the NHS in delivering central requirements and this complemented a lot of work which was going on within the Department both done by civil servants and done in fact by some other consultants, including Coopers & Lybrand, and the whole exercise is

The cost of printing and publishing these Minutes of Evidence is estimated by HMSO at £4,900.

[**Mr Trend** *Cont*]
intended to identify information requirements of the Department and to check whether information was justified to the extent that we could actually put the burden that we do impose on the NHS in providing information. The current state of play is that seven returns have been dropped, two have been incorporated into material that the Department is collecting in other ways—through a manpower census and some financial returns—and we are going to undertake a review of a further 30 returns over the next few months with a view to changing the situation next April, if it is possible to get a review agreed by then with the NHS and those who are interested in the work that we do.

3. Will there be any consultation with the users outside the Department or the Government Statistical Service about those changes?

(*Mrs Butler*) There have been some consultations within the Government Statistical Service, particularly on manpower returns, which are of interest for national accounts purposes. We do have a variety of ways of having contact with people outside and we shall be using all those routes to sound people out about the changes that we are making.

4. Is it possible that a copy of the Touche Ross report might be available to the Committee?

(*Mrs Butler*) There is not actually a Touche Ross report in a form which is free-standing. There is a report on the hospital and community health service information strategy which is currently available within the Department and I can make enquiries about whether people are comfortable for us to make that available to you at this stage.[1]

Mr Congdon

5. The quotation by ministers of unpublished statistical information from the NHSME's management returns and the fact that the data is sometimes collected in different ways and using different criteria from the information published in other quarters does sometimes cause concern. Why is it felt inappropriate to publish the NHSME management returns?

(*Mrs Butler*) I think the fundamental problem is that there is a lot of information which is collected very quickly, sometimes over the phone, and in order to inform discussions that the NHSME are having with people who are managing the Health Service. Consequently it is not necessarily on standard definitions, and because it is to form the basis of discussion and not to form part of a national and statistical total, then it does not go through the normal rigours of validation. I think that is really the reason for caution about making things available when they have not been collected with that purpose in mind.

6. Could that same caution not apply to any information that ministers are going to quote in Parliament?

(*Mrs Butler*) I think in the case of information that is quoted in Parliament, then they usually are very wary about whether it is fully validated information or not.

7. Can I just pursue that point? Are you aware of situations where they have quoted NHSME information that has not been made publicly available and could and ought to be made publicly available?

(*Mrs Butler*) I cannot think of any instances. I do not know whether my colleagues know of any. No, I do not think so. I think on occasions when some information from those sources has been used it has always been very clearly stated that that is where it has come from.

8. Can I follow that up because it is an important point? Have the NHSME got a proper management information system that gives them real information which has been validated and if it has been validated, is it then made available and, if not, why not?

(*Mrs Butler*) Of the information that has come via a central return and goes through the full validation process, I am not aware of any of that that is not made available or would not be made available if somebody asked for it. We certainly are not sitting on anything which is collected by any of us which is not made available.

Mr Sims

9. If I could just clarify, presumably there is some information which is not necessarily published but is available if asked for, for example by Parliamentary Question?

(*Mrs Butler*) Indeed. I think you can see from our list of publications that there is an enormous range of information that we make publicly available already. I would have loved to bring a forklift truck to show you because I have never actually seen it all in one place at one time. Some of it, such as Health Service Indicators, is only available on computers simply because it is so voluminous. Beyond that, the material that is made publicly available, there are levels of detail which, if people do enquire, we will make available but to make it regularly available all the time would be a very expensive proposition.

Mr Clappison

10. Can I turn to the question of provisional waiting time information which is collected for management purposes and published on a quarterly basis?

(*Mrs Butler*) Yes.

11. On this question of provisional waiting time information, could I ask if this data has now been integrated with the data collected by the Körner returns?

(*Mrs Butler*) I would not say integrated as such. We look at both sets of information, as you understand. The provisional fast track waiting list figures are at a very highly aggregated level and the Körner returns are much more detailed. People within the statistics branch in Leeds who deal with the Körner returns work extremely closely with the waiting times unit who do the fast track (provisional) figures. Integrated is a slightly complicated concept. They look at the two sets of figures alongside each other.

12. Turning to the way in which the waiting list material is published. It lacks some of the data and

[1]See Supplementary Memorandum, Annex G, p31-32.

[Mr Clappison *Cont*]
footnotes which I believe were available on the earlier version. I wonder if you can go into that for us and say whether or not you think it would be useful to know how many people, for example, were removed from waiting lists for reasons other than treatment and how many people self-deferred in each period?

(*Mrs Butler*) I am not sure how much I can help you on the detail of that. You are talking about the standard Statistical Bulletin that has been simplified in certain ways and you have in that process actually lost some information you would like to retain?

13. Yes. It used to be there under the old system.

(*Mrs Butler*) I think that could be restored.

(*Mr Derry*) It was simply a case of trying to make the publication more accessible and useful. The information still exists and if there is a demand for it I am sure we will reconsider. It was simply about shortening what is already a detailed and lengthy document.

Alice Mahon

14. Would that extra information tell us, for instance, how many people have gone on to the private sector? Did it before and would it now?

(*Mrs Butler*) No, it did not.

15. Could it be done? Would it be very difficult?

(*Mrs Butler*) At first blush it sounds as though it could be quite a difficult thing to do. It is something that we could consider. It is not on our consideration list at the moment.

Mr Clappison

16. On the question of people removed from waiting lists for other than treatment, is there any way in which this could be analysed to show people who fall into that category have been on the list for over one year, over two years and so forth?

(*Mrs Butler*) There is information on the length of time that people have spent on the list as well as the length of time people currently on the list are on the list and estimates of that are made.

(*Mr Derry*) There is no direct information on the amount of time people wait before they are removed from the list if their removal does not involve hospital treatment.

Chairman

17. Before I ask Mrs Wise to come in, could I just ask you: could you tell us what was announced in the written answer that came out today to Mr Alan Duncan who asked the Secretary of State: "pursuant to her Answer of 23rd November; if she will now announce the results of the review of her Department's requirements for information from the NHS". Do you happen to know what the answer to that is?

(*Mrs Butler*) Yes, I do have the answer to that question with me. Shall I just read it as written? Are you happy for me to do that.

18. We actually went and got an Order Paper in order to make sure we got the answer from you.

(*Mrs Butler*) It says: "In order to reduce the burden of form-filling on the National Health Service, it has been decided that the Department will no longer require the NHS to provide the following returns: KH18, which is the maternity services, GP maternity clinics return, that only relates to the very few clinics held in hospitals; KP20, Summary of ward stays (provides an inappropriate measure of activity); KP72 which relates to regular day and night admissions, information which we do not use centrally; FR19 which is about the purchase of health care from non-NHS bodies and grants to voluntary bodies (this information is not used centrally); the FR26 which is an analysis of stocks; the FR27 which is about fixed assets and the MA01 which is the monthly return on provider activity.

19. Thank you very much.

(*Mrs Butler*) That is not entirely verbatim but it is close. It then explains, as I was explaining earlier, that the detailed content of some of the other returns is also being reviewed.

Chairman: Members will be able to look at that more closely and get the detail.

Audrey Wise

20. Progress on improving the completeness of data in terms of the maternity hospital episode statistics is very slow, can you tell me what steps are being taken to improve their completeness, and has the internal market helped or hindered in this?

(*Mrs Butler*) I think if I can answer in very general terms and then turn to Mr Willmer to take us through some of the detail with which he is more familiar. I will talk generally about HES (hospital episode statistics) in total. The coverage of episodes within HES has increased over the years: in 1977/78 it was about 88 per cent; in 1988/89 it was about 93 per cent; in 1989/90 it had gone up to 97 per cent. The figure for 1990/91 is slightly interesting, it comes out at 101 per cent entirely attributed to one region. In 1991/92 it is at 99 per cent. I think the coverage of HES in relation to our Körner aggregates on the activities going on in the Health Service is improving all the time. We are also getting a massive improvement in the percentage of records with a valid diagnosis and that has gone up from 75 per cent in 1987/88 to 95 per cent on the provisional figures this year.

21. I do not understand that. You did rattle it through a bit. I am not sure whether I have misheard you or whether it is an entirely different kind of thing and I am on the wrong track because I asked a Parliamentary Question in this connection and, for instance, I got an answer on 12th March which told me there were 665,965 deliveries in England during 1990/91 and that there were 400,448 delivery episodes recorded on the maternity hospital episode system for the same year.

(*Mrs Butler*) I think I may have confused the issue. I did say, and probably not clearly enough, I would tell you about the overall HES and then I would ask Richard to tell you about the maternity HES.

22. I see, that is the overall HES.

(*Mr Willmer*) The position on maternity HES is as we gave in the answer on 12 March. Again, the coverage is improving. We are working with colleagues in the Management Executive who go out to the NHS to try to make sure as much information as possible is actually put on to the maternity HES

[**Audrey Wise** *Cont*]
system because we are concerned about the shortfall in the records that come in.

23. Why is there this shortfall? The figures you have given for the overall are quite impressive and yet for maternity, where figures are very important as well, the figures are appalling, why?
(*Mr Willmer*) The particular problem on maternity seems to be the transmission of data locally from maternity systems into patient information systems that then go up to regions and then come to us at the Department. The overall position on maternity has not been as good as on HES overall.

24. Does that mean the system is actually inappropriate for the collection of maternity statistics? Does it mean that the Körner system actually does not fit into the collection of maternity statistics?
(*Mrs Butler*) I think we had a problem when we introduced the Körner system as I think a number of Members of the Committee are aware. It took some time to get it moving which is reflected in figures I gave you earlier. I think we have just got more severe difficulties in relation to maternity than we have in relation to overall normal episodes. I think it is something we obviously need to persist with and try to improve.

25. Is that because maternity is a process that is not readily reducible simply to hospital episodes?
(*Mr Willmer*) I think it is more a sort of detailed issue about how information is recorded locally, that it is often on separate systems which then need to be fed through to the main patient information system where most of the records for acute specialties are held.

26. So it means that some of this will actually never be recoverable, does it not, this information?
(*Mrs Butler*) Historically we will not recover it.

27. Is it also still correct that when this system was changed in 1985 there was not even an attempt to collect the statistics for 18 months so there is a total gap for 18 months?
(*Mr Willmer*) The NHS was given a 12 or 15-month reprieve initially in order to get the new HES in and then the maternity element was delayed a further year, so yes, there was a period where the NHS was not expected to submit data.

28. It did not supply any maternity statistics at all?
(*Mr Willmer*) Not the supplementary data on HES.

29. What should be included in the statistics?
(*Mr Willmer*) There is a detailed list of data items referring to the delivery of a child and birth information. I could provide you with the details of what is actually on the maternity tail, as it is called, which is the extra data provided.[2]

30. I think perhaps the Committee would like that and some of this will relate to things like the birth weights, will it?
(*Mr Willmer*) Yes, things like that.

31. So it is particularly sad that this information will not be ever available in any complete and proper form since research shows that birth weight is very important as a predictor of future health.
(*Mrs Butler*) Yes, and we hope to improve the data in future, but there is no way we can retrieve the past.

32. When you have got this and you are busy analysing the completeness and value of the data which has just been collected, when you have done that will it be published?
(*Mr Willmer*) Yes, we can certainly do that. We have produced it in the past and we can produce the same tables as were provided to the Committee about 18 months ago.

33. Will you be doing that in a routine way or just if we ask you?
(*Mrs Butler*) I think we would hope to get round to doing something on a routine basis.
(*Mr Willmer*) We are looking at the rest of HES and publishing that in a routine way. We have not decided what we are going to publish on maternity yet because it has not been in a sufficient form to actually do that.

34. Could you let the Committee see a copy when it has been published?
(*Mr Willmer*) Well, perhaps I should turn it round the other way and say that if you ask us, we can certainly do that.

35. Yes, we will ask you and perhaps we might want to give you some advice about what you should publish.
(*Mrs Butler*) There is birth weight information available from birth registration data and that might be a source that we could pursue.[3]

36. It is very, incomplete but yes, possibly it is a starting point. Is it that there are certain hospitals that do not co-operate properly and, if so, do you have a list of these and should you publish that list?
(*Mr Willmer*) We know there are certain regions and certain districts within regions where there has been more of a problem than elsewhere and those are the particular areas that the Management Executive target when they visit the NHS. They regularly visit the regions and they target the areas where there is poor response.

37. So it would be possible to get that in the public arena if we ask questions on it no doubt?
(*Mr Willmer*) Yes, information on coverage is available.

38. Have you thought of rather more Draconian methods, such as, for instance, could district health authorities be instructed to withhold payments to providers who do not submit their data on their invoices?
(*Mrs Butler*) That is not actually something we have thought about. I do not know whether colleagues elsewhere in the Department have thought of it, but we have not considered it in Statistics Division.

39. It might produce some spectacular increase in co-operation, might it not? What percentage of live births have been submitted to the Department for the maternity hospital episode system for the South West and West Midlands regions for 1991?

[2]See Supplementary Memorandum, Annex B, p22-26.

[3]See Supplementary Memorandum, Annex G. p31-32.

[**Audrey Wise** *Cont*]

(*Mrs Butler*) I am not sure whether we have that information with us.

(*Mr Willmer*) We do not have that separately. I know those are two particular areas which have not been as good as the rest of the country. I can provide that separately. Overall, for the country it has been about 80 per cent of births, so for 1991/92 we have actually got a better response. As I said, it is improving as part of the overall improvement in HES that Mrs Butler referred to.

40. So you might like to send us some specific information?

(*Mr Willmer*) Yes.[4]

Chairman

41. Are you able to give us any indication at all for South West and West Midlands regions, what the answer is likely to be?

(*Mr Willmer*) I have not got the information with me here.

42. You have not got any information at all here?

(*Mr Willmer*) Not with me at the moment.

Audrey Wise

43. One last thing. There were statistics collected and a follow-through for cohorts of babies born in a particular week roughly every 15 years or so for a considerable time and that seems to have stopped entirely. These babies were followed through the cohorts, and provided extremely valuable information. When I last spoke to the OPCS about it they were not able to give any information about when that would ever be done again. Can you shed any light on that?

(*Mr Willmer*) That is an OPCS system rather than a Department of Health system. That is a longitudinal study which the OPCS undertake. As far as I know, it is still in existence.

44. Well, it is not. The present ones are, but there are no fresh ones for a long, long time.

(*Mrs Butler*) I think that is an issue that needs to be raised with the Office of Population Censuses and Surveys rather than with the Department.

45. Or with the Department itself or with the Minister?

(*Mrs Butler*) We share a Secretary of State, but they are a separate department.

Mr Sims

46. You explained in your initial response to Mrs Wise that you have had rather more success in general terms in collecting hospital episode system data.

(*Mrs Butler*) Yes.

47. And that maternity is—I hesitate to use the words "black spot"—a difficult area. Can you tell us to what extent this material has been published?

(*Mrs Butler*) We have not published any information directly from HES in the past. We are at present putting together our very first publication, having done a lot of work with Professor Balarajan of Surrey University helping us to gross up the figures, and we are working on the publication now which we hope will be out in a couple of months' time.[5]

48. Will that be bald statistics or are you analysing it in the sense of age, reason for admission, type of operation?

(*Mrs Butler*) There will be summary tables of various sorts. It will not be just the raw data. It will be analysed, but we were not actually endeavouring to do a large quantity of text to go with it because we are keen to get it out.

Chairman

49. For what years are we talking about?

(*Mr Willmer*) This is 1989/90 and it covers very detailed tables of the type of information that we are asked for regularly and the type of information we know outside users wish to receive, so it covers very detailed analyses similar to the old hospital in-patient enquiry analyses which were produced.

Mr Sims

50. Will this include what I think you described as "finished consultant episodes"?

(*Mr Willmer*) Yes.

51. And, if so, is there a distinction between such episodes and the number of people actually treated? There have been suggestions that there is a certain amount of duplication here.

(*Mrs Butler*) The consultant episode is a period in hospital the patients spends under the care of a specific consultant, as I am sure you understand, and a spell in hospital can comprise one or more such spells if you move from one consultant to another. The definition we currently use stems from the first Körner Report so that the workload of individual consultants or speciality groups can be properly recorded. In the year that we made the change from deaths and discharges to finished consultant episodes we did actually do it on both bases so that we could compare the two.

Alice Mahon

52. So it is a single stay in hospital?

(*Mrs Butler*) Yes, under a single consultant.

53. So the same person could be counted two or three times if they were in and out of hospital?

(*Mrs Butler*) Yes.

54. So that if they were in three times there would be three episodes, although it is the same person?

(*Mrs Butler*) Yes.

55. That is obviously going to have a big effect on the elderly people and the revolving-door policy so there are not necessarily more people being treated, but it is the same person going in and out?

(*Mrs Butler*) It is possible.

(*Mr Willmer*) But on the previous discharges basis the same could have happened.

[4]See Supplementary Memorandum, Table 1, p. 26.

[5]Footnote from witness: The first HES publication is now available, containing detailed tables of numbers of cases by diagnosis and operative procedure and includes analyses by age groups, sex and region of treatment.

Mr Congdon

56. Just a quick follow up to Mr Willmer. One of the important things about the information is the time limits. In this day and age of increased technology why does it take so long to get up to date information? I think you said it was 1989/90 which is about to be published, in statistical terms that is almost Stone Age. Why are you not now in a position certainly to publish 1991/92 and 1992/93 even, which finished a couple of weeks ago? What is the problem?

(*Mr Willmer*) First the time it has taken: as we said in earlier years the data was incomplete and we had to do a very careful exercise because there was not a regular shortfall across the country, it was different between regions and it was different between medical specialties. If we had rushed in and produced the information quickly we could have come up with some wildly inaccurate figures so some careful work had to be done and we have had the benefit of Professor Balarajan through Surrey University to help us look at it. It takes time to set up a publication. Although this data relates to 1989/90 we have also used quite a bit of 1990/91 data which people will probably find in Parliamentary Questions and from other sources. In fact the 1991/92 data is about to be transferred to the Health Service indicators' packages we are about to put out. So although the publication of data is for 1989/90 we are using more recent data. The timescale in producing information does vary. Regions are asked to submit the data by about three months after the end of the financial year and obviously we have not started 1992/93 yet. Once it comes in if we find problems we have to go back to the regions and have to have a discussion with those regions and it often takes some months to actually sort out the data before it is in a position where we can use it. The only other point I would like to make is that even though it is 1989/90, it is still very welcome information because it provides a lot of details about how resources are utilised in hospitals. Many aspects do not change a lot year by year but it is the first information many have had since 1985, so although it is out of date it is also very welcome to a lot of people.

Mr Bayley

57. I wanted to follow up the point that Alice Mahon was raising. Partly because of the increased use of day surgery and partly because of the pressure to use beds efficiently there is a folklore at least, and I think it is probably true, that there is an increasing early discharge and increasing need to readmit. Would it not make sense for the Department, as well as analysing consultant episodes in the way that you do, to provide a comparable but separate set of figures which relate to consultant episodes for a particular patient? After all, it is the purpose of the Health Service to care for individuals, not to put through x number of people on a production line through a particular procedure.

(*Mr Willmer*) In order to do that one would need to link records to individuals which would mean having some identifier of the patient at the centre, and it has been decided in the past that we should not have that. It was specifically recommended in one of the Körner Committee reports that we should not have identifiable patient information at the centre, therefore what we can measure is the episodes of care.

58. But surely you can overcome that problem because the data must be drawn at some point from the records of the individual, must it not? That must be a trigger of some kind.

(*Mr Willmer*) It is fed in locally at the end of the episode for that person.

59. Yes, but it is not beyond the bounds of possibility for the data collector to look not just at the last line of the medical record but at the previous medical history to see if it is a readmission? Perhaps the very simplest way to do it is just to recode an episode if it is a readmission for a similar condition that was treated within the previous 24 months?

(*Mr Willmer*) We receive some readmission information on psychiatric patients which is not particularly well recorded quite often.

60. Do you acknowledge that there is a gap in information there which somehow—we are not going to work out how to address it properly this afternoon—but somehow there is a worrying gap and it would be helpful if it is plugged?

(*Mrs Butler*) Yes. I think there is a genuine interest in what you have raised and it is something that we can address.

Alice Mahon

61. What changes are being made in the collection of data about numbers and grades of staff employed in the NHS? Is there any attempt to collect data about staff employed by private contractors? That is two points really.

(*Mrs Butler*) There are no major changes in the way that data about staff numbers in the NHS is being collected and at present we are not collecting numbers employed by private contractors.

62. Is that under Government instruction or has it been decided not to do the private contractors?

(*Mrs Butler*) There is no instruction not to do it. I have not been instructed either way.

63. You do not think it would be a good idea if we are trying to keep an eye on grades and the numbers of staff?

(*Mrs Butler*) It is not something that I have been advised that there was a need for.

(*Mr Willmer*) I think if you collect information on private contractors you are getting into the business of exactly how many people are employed directly or indirectly in the Health Service and there are rather difficult boundaries as to what the statistics actually represent.

64. You can see from our point of view that is what we might want to know. I think, talking about people employed by private contractors with the changes and some of the things that have gone on over the past few years, are there any additional problems being encountered in obtaining data from trusts, compared with the directly managed units?

(*Mrs Butler*) Yes. I think we have to confess that we have had some difficulties in relation to trusts. The advent of trusts has unavoidably put significantly extra strain on us to provide information. In the past we have relied very much on the regional tier to help us co-ordinate information at district level but

[**Alice Mahon** *Cont*]
obviously this is no longer the case and the number of trusts has risen very fast, as you are aware, from 50-ish to approaching 300 now, so there is an awful lot of extra work put on us to actually produce data at the national level.

65. Is there an attitude and is there a trend amongst the trusts?
(*Mrs Butler*) About providing data?

66. Yes.
(*Mrs Butler*) I think on the whole the trusts have accepted very well that it is part of their obligation to the Department to provide information for central returns and they are doing their best to do so. Obviously we have had to build up new relationships with the trusts which we did not have at all with the directly managed units because we went through the regions.

Mr Bayley

67. The question David Congdon raised about the delay in publishing statistics, the impact of it has finally dawned on me. 1989/90 was before the Health Service reforms.
(*Mr Willmer*) Yes.

68. So does that not rather cast doubts on the statements that everybody, ministers and people on our side, have been making about increases or decreases in activity?
(*Mrs Butler*) Perhaps I could step in on that one. Basically the activity is monitored much more rapidly. The hospital episode statistics system is incredibly detailed information about every single episode but we do have the Körner activity data which is published much more frequently.

69. When will post-reform hospital episode data, the full data, be available?
(*Mr Willmer*) The first set of that is currently going into the Health Service indicators' package for 1991/92. Overall activity data has already been produced.

70. You are saying you do not know when that would be available; would you like to hazard a guess?
(*Mr Willmer*) The hospital episode statistics will be going into the Health Service indicators' package for 1991/92.

71. When will that be?
(*Mr Derry*) We hope to get them out towards the end of the summer.

72. That is available to hospital managers and also to the general public, to researchers and so on?
(*Mr Derry*) Yes, and a copy is lodged in the Library of the House as well.

Tessa Jowell

73. Can you tell us what data systems are being used to monitor the new community care policies and particularly whether the new policies have given rise to new data collection systems being introduced?
(*Mrs Butler*) I think perhaps we can take this in various pieces. The Health Service information includes already information on day care and the community health service. We have a set of Community Health Service returns and we have information on drug misuse which links across the community as well as the Health Service side. The future of many returns in that area is under review at the moment and we will take the advent of community care very much into account as we take that forward. Personal social services information is perhaps even more relevant to the community care side and there have been changes in the routine statistics in part as a result of community care in returns on home help, home care, day care and the meals services.

74. Can you tell us what kind of changes?
(*Mrs Butler*) There is an awful lot of detail here and so I wonder whether in fact it might be easier if we write and let you know the detailed changes rather than try to go over them here when we have not got the returns in front of us, either the old or the new ones. Would that be acceptable to the Committee?[6]
Chairman: Yes.

Tessa Jowell

75. One of the issues which has exercised the Committee a lot is the concern that the Department do not intend to monitor levels of unmet need identified in the course of assessment for community care. Are you confident that from a technical point of view unmet need can be measured?
(*Mrs Butler*) I have not actually undertaken any work in this particular area. I think we really ought to wait for the Government response to the Committee hearings on community care where a number of questions on information were raised and I think that will come out in that context.

Chairman

76. Can I just pick up this particular point? If you can record destination on discharge in Wales, why do you not do so for England?
(*Mrs Butler*) I was not aware that the Welsh did that, but I can certainly ask them how.

77. Apparently it is done in Wales, so I have been informed.
(*Mrs Butler*) It is something we can enquire about.[7] I am sorry that I cannot help you directly on that.

Mr Bayley

78. Now that you have replaced the Health Service price index with the Health Service cost index, why do you not use the Health Service cost index to adjust the figures in your annual reports so that the general public is aware of relative costs and relative spending? I know you do it subsequently in your returns to this Committee.
(*Mrs Butler*) Yes.

79. But that is not a document that is readily available to the public and surely these figures should be produced a little bit earlier and put in the annual report?
(*Mrs Butler*) I think that the main reason is that our departmental report is part of the series of public expenditure reports produced under the auspices of

[6]See Supplementary Memorandum, p. 11 and p. 27-30
[7]See Supplementary Memorandum, p. 12 and p. 30.

[**Mr Bayley** *Cont*]
the Treasury. Although it is a separate departmental report these days, it is part of a suite of reports produced across all departments and it is standard practice in there to use the GDP deflator when putting figures into real terms.

80. But it is not an appropriate deflator because otherwise you would use it generally in the Health Service.
(*Mrs Butler*) Well, I think then that is an issue to raise with the Treasury rather than with me or perhaps with our Finance Division.

81. Or possibly with health ministers?
(*Mrs Butler*) Or possibly with health ministers, yes indeed.

Mr Trend

82. I have a number of short questions about the HES data. We understand that from April 1 this year you have to include information about ethnic origin. Is this system in place and working and, if not, what progress is being made in recording the ethnic origin of patients?
(*Mr Willmer*) The HES system has a space for recording ethnic origin which can be used at such time as the NHS is ready to provide it. At the moment it is being tested out in the NHS and I understand that there are still discussions going on with ministers as to whether it should be formally part of the contract minimum data set, as it is called.

83. Which it is not at the moment?
(*Mr Willmer*) Which it is not at the moment.

84. Do you know what areas are testing it? Is there a little interest, a social interest?
(*Mr Willmer*) I do not know which they are off-hand, but I could probably let you know.[8] I have not been personally involved in that, but there has been testing going on of it.

Mr Congdon

85. I was going to make a passing comment because, as I understand it, some information does come out on health which shows the incidence of some diseases is more prevalent amongst particular ethnic groups. Would it not on that basis be useful for it to form part of the standard data that is collected so that the NHS can ensure that resources go to those who need them?
(*Mr Willmer*) I think ministers have mentioned that it is seen as an important aspect of looking at public health. There are issues which are being addressed at the moment with the Data Protection Registrar and others as to whether it is an appropriate item to be collecting locally in the NHS.

Mr Trend

86. From April 1 we also understand there is to be the establishment of population-based health registers. Can you tell us the state of play on this? We understand you hope to establish integrated data from hospitals elsewhere to give a clearer picture of the health status of given areas.

[8]See Supplementary Memorandum, p. 12.

(*Mrs Butler*) I think this is an initiative which is being taken forward under the information management and technology strategy which is being managed by the Information Management Group of the Management Executive and it is their intention to work towards having population registers. There is also a general trend towards single client databases in the personal social services which would improve the quality of statistics in that area as well. The timescale for the population registers in the NHS is a possible introduction in 1995/96, but this is, as I say, under the auspices of the Information Management Group of the ME.

87. The other thing was the definition of social class. We know this is notoriously difficult, but important to effective analysis. What is being done to include data on social class in health statistics?
(*Mrs Butler*) There is no social class dimension in any of our standard returns at present. There is information on social class available from sources like the General Household Survey which also contains information on health. There is also information on social class in the health survey on which work is currently in hand and publications are currently being prepared. However it is not an easy dimension to include, as you can imagine, in the ordinary patient registration data on which standard returns are based. There are certain bits of information which can be considered to be a proxy and there is some occupational data in relation to mortality in the OPCS statistics, but there is really very little we can do in relation to standard returns and regular returns. I think surveys is the right way to approach that.

Mr Bayley

88. I have two quick questions, if I may. I understand that some firms of market researchers these days use on an aggregate basis postcodes as a proxy for social class and they are making assumptions that a council housing estate in a particular area is full of people of a mix of ethnic and social classes. Could you not use that sort of postcode data because you will have postcodes for many of your patients now which would allow all sides of the Committee to look and see whether the Black Committee-type projections are widening or not and also possibly over time to monitor the effect of local public health policies on infant mortality amongst social classes in a particular health district and so on?
(*Mrs Butler*) It may be possible to do something. I see this really more as a research-type approach to looking at what we can discern from postcodes and whether it is meaningful rather than something one would do right across the board as a standard statistical matter because I think you could get horribly misled by making broad assumptions about social class in relation to postcode areas. One could perhaps use some information from the Census of Population which we do, for example, for the Jarman index, the deprivation index, which feeds into the funding of GPs, but it is based on a very complicated set of assessments and probably not at the fine level of detail that you would have in mind.

89. Secondly, on the question of population-based registers, I was rather concerned to learn that you did

[**Mr Bayley** *Cont*]
not think there would be anything usable until the middle of this decade. Since the population now is the key to funding, I know SMRs are put into the capitation funding formula, but overwhelmingly the amount of money the health authorities get depends upon the size of its population and its age mix. Are you able at the moment to postulate the range of differences you could get between the OPCS figures which I suppose are used at the moment and the figures for population mix that you would get from the population-based health register because it could amount to millions of pounds per health authority, up or down?

(*Mrs Butler*) I think we have to bear in mind that the population estimates already use FHSA information which is held on the National Health Service central register, so there would be a gradual improvement in the quality of that, but I do not see it being a step change improvement in quality of that, so I think it is going to be marginal rather than substantial.

90. You get step changes every ten years with the Census though, do you not?

(*Mrs Butler*) Yes.

91. You could have a step change five years into the Census period, could you not? Is there not a potential policy problem of some health authorities?

(*Mrs Butler*) Yes, but I think the thing that we have got to bear in mind is that hopefully we would have a good base for improvement if we start analysing in the middle of this decade. We ought to have by the end of the century something that would smooth out that problem if in fact the pilots were successful and we decided to go ahead with them.

Audrey Wise

92. On the social class aspect this is, of course, particularly important information in relation to health and disease and differential occurrences and differential outcomes. I am very concerned about what you said. I am particularly concerned in relation to maternity because it is known quite definitely that social class has a huge bearing on the outcome of both the mortality and probably morbidity as well as general health. You did mention that you drew some information, or some information could be drawn, from the OPCS social class statistics, I thought you said that?

(*Mrs Butler*) Yes.

93. But it seems to me that this is relying on a very broken reed, certainly as far as maternity is concerned, because we have already ascertained previously from the OPCS that, for instance, there is no social class information, virtually none, except for babies born in wedlock and there are large numbers not born in wedlock, so there are figures given about social class which are based really on a declining percentage of actual births. Am I to understand that this is not something which is under discussion at all as far as you know?

(*Mrs Butler*) No, it is not being actively discussed at the moment.

Mr Clappison

94. Can I just ask you briefly to enlarge on what you were saying about occupational based research. How easy would it be to prepare a full picture of occupational based research and to what use could it be put?

(*Mrs Butler*) You mean the occupation in relation to the mortality?

95. Yes indeed.

(*Mrs Butler*) It really depends what questions you want to have answered and then we can find the answers.

96. I was wondering how easy it would be to put together a complete picture of the relationship between occupation and morbidity and mortality?

(*Mrs Butler*) Certainly the OPCS do produce a series of monitors in that area, though I am not familiar with the details of all of them. I think they extract from the data what they think is the most useful and the most relevant to the outside world.

Mr Sims

97. Could you tell us how for statistical purposes you define an "available bed"? Is that simply a piece of furniture or does it imply that there are the necessary staff to service that bed?

(*Mrs Butler*) Our bed availability figures are based on places available for treating a patient rather than a count of beds as such. Trolleys and cots and other such conveyances also get counted as "available beds".

(*Mr Willmer*) The staff structure has to be there as well. It is not just an empty room with beds and no staff.

98. That is the point I am getting at, that you also have the figures of staff and are satisfied that not only could the patient be put in the bed but there are the staff there to look after the patient.

(*Mr Willmer*) Yes. That is the definition the NHS is asked to use.

99. What is the definition, what I have just said?

(*Mr Willmer*) Yes. What Mrs Butler said. The infrastructure has to be there. The bed has to be available for the patient which includes having the staff to look after the patient.

Mr Bayley

100. If it is a surgical bed does it include having theatre time at the start?

(*Mr Willmer*) It will just be a bed available for the patient. I think it would be difficult to link it through to an operating theatre session.

Audrey Wise

101. What input does the Research and Development Division have into decisions about what data are collected by the Information Division?

(*Mrs Butler*) It is quite complicated to explain the relationship between ourselves and the RDD. You will undoubtedly be asking Professor Peckham for the other side of this question. A substantial part of the work that we do is very separate from the work that they do. Perhaps this is the point at which I should mention our information strategies which we

[**Audrey Wise** *Cont*]
touched on earlier. The statistics branches are responsible for four information strategies: hospital and community health service; family health service; personal social services and public health. On those four big chunks of the Department's business we look at the information required in those areas. We trawl very widely around the Department, including RDD, when we are trying to decide strategically what information we need over the coming years. Because we look at it in four chunks we also have a co-ordinating committee, which I chair, to make sure there are no nasty gaps or potentially expensive overlaps between demands coming from one area of the Department and another. RDD are also represented on that group. There are a number of exercises which we undertake during the year, for example when we trawl the Department to find out what information people require from our social survey programme we do a joint trawl with RDD when they are going out to ask the Department about research needs. We do that simultaneously with them so that when people are considering their research needs they are considering whether they want a detailed research project and what surveys are appropriate. We actually try and co-ordinate our work in that way. We also work on a one-to-one basis with particular research projects. Then there is a huge supply of information from all statistical branches to different people doing research in the field.

102. What sort of factors then will be the deciding factors, as it were?

(*Mrs Butler*) I think really it probably gets to quite a detailed level in discussing a particular policy concern or medical concern before deciding which way to actually try and probe it. It might be an adjustment to the central return, which is probably unlikely. It is more likely that we would put some questions in the General Household Survey or one of the omnibus surveys which we use for things like smoking. It might be an appropriate health survey question or a research project on a particular area or particular treatment or condition. Having done a broad brush trawl around it then gets down to discussion on a smaller group basis to decide which is the right approach for a particular problem.

Chairman

103. I would like to put the final two questions to you relating to market testing. What standards of quality and timeliness have been developed for inclusion in the invitation to tender for the running of the hospital episode system? Secondly, in preparing for market testing to what extent have you identified the current in-house costs of the HES and will you be making an in-house bid for the contract on the basis of increased resources needed to achieve something better than the current standard of quality and timeliness achieved in the collection, analysis and dissemination of HES statistics?

(*Mrs Butler*) Perhaps I should explain that the basic processing of the hospital episode statistics system is not undertaken by the Department so consequently we will not be making an in-house bid for the work. The bulk of the work is done by the Office of Population Censuses and Surveys and a chunk of work is done by ITSA which is the Information Technology Agency for the Department of Social Security who take a broadly 25 per cent sample of the data and provide us with tables and facilities for *ad hoc* analysis. The resources are not in-house so there will not be an in-house bid. We have been working very closely with colleagues to decide about various aspects of the quality and timeliness, but we have not yet made final decisions on that. We are currently drawing up a business case for the hospital episode statistics system and we have not made final decisions on precisely what timeliness and quality will be.

104. Is it possible for the Committee to see that?

(*Mrs Butler*) I think probably the best thing would be to let the Committee have the invitation to tender when it is ready, if that would be acceptable, because that will be a document in a form that is readily understandable for outside use. Some of the internal stuff is a bit dense in places. You were asking about quality and timeliness issues and—

105. And how you identify the current in-house costs of the HES?

(*Mrs Butler*) We know how much we pay the Office of Population Censuses and Surveys each year. There is a small internal staff cost. In fact, we do not know precisely the costs paid to ITSA because these costs are part and parcel of the larger payment from the Department to ITSA for a range of computer work which it is not actually possible at the moment to disentangle. So we know how much we pay through OPCS and there is a small internal staff cost for the processing and liaising with the Health Service through IMG.

Audrey Wise

106. Presumably then the equivalent of an in-house bid is the OPCS making a bid?

(*Mrs Butler*) Yes.

107. So presumably it is doing that?

(*Mrs Butler*) We are expecting them to make a bid but they have not formally said they will do so.

108. The thing which strikes me is that for the people who do not at present do the work it will be quite easy for them to make claims and assumptions about what they can achieve in quality and timeliness and there will be no proof of the pudding, as it were, whereas the OPCS, they of course have been grappling on the basis of inadequate resources. How are you going to achieve real equality in the judgment which will be made in deciding on the bid?

(*Mrs Butler*) I think you have touched on one of the issues that we are going to find really quite difficult and I do not think we can deny it is a very difficult exercise to measure up someone who is not tried and tested against someone where we know the quality of what they can do and how they can do it. Obviously we shall do our absolute utmost to ensure that we are treating everybody on a level playing field and to explore with people other work that they are doing and of a similar type and possibly talk to their other customers and so on to ensure that they do have the capacity and the skills amongst their staff to undertake the work which will be necessary.

109. I remember back in 1987/88 being given absolutely glowing forecasts of the effect of Körner when it was fully on-stream and all that and of course

[**Audrey Wise** *Cont*]
it has proved to be far from glowing in its actual working and so it is easy for things to be projected in a very positive and optimistic way.

(*Mrs Butler*) Yes.

110. I am still worried about how you are going to guard against that because it seems improbable to me that there are many people whose work can really be compared in scale and complexity with the OPCS.

(*Mrs Butler*) There are several people out there who have expressed an interest in undertaking this work and some of them do carry out similar sorts of operations, not hospital episode statistics, but large-scale data collection of quite complex data.

111. Of course if they get the contract and then we get in a few years' time exactly what has happened with Körner, it will be a little bit late then and the Office of Population Censuses and Surveys may have gone to the wall in the meantime.

(*Mrs Butler*) That is always possible.

Chairman: Well, I am afraid I must draw this session to a close. We have overrun our time. It has been very interesting indeed. Can I on behalf of the Select Committee Members thank you, Mrs Butler, Mr Willmer and Mr Derry, very much indeed for coming before us this afternoon and answering our questions in such a full and frank way. We are extremely grateful to you.

Memorandum Submitted by the Department of Health following evidence from the Director of Statistics on 21 April 1993

(Q numbers refer to Question numbers in the oral evidence)

Q4 *Mrs Butler undertook to discover whether the report on the HCHS information strategy could be made available to the Committee.*

The draft report on the HCHS Information Strategy is shortly to be submitted to the Management Executive for its endorsement. Once the report has been finalised a copy will be made available to the Committee.

The Committee is aware of the central "Korner" returns which have recently been discontinued following a review lead by the HCHS Information Strategy. This exercise established the current justifications for the remaining returns and these have been collated in a report for circulation to the NHS. A copy is attached at Annex A for the Committee's information.

Q29 *Mrs Butler undertook to describe the items included on the "maternity tail" of the HES.*

A list of the items in the "maternity tail" of HES is attached at Annex B.

Q35 *The Committee would like to receive the most up-to-date maternity HES data in parallel tables to those provided to the former Committee and referred to in the answer to Q32.*

Tables are set out at Annex G.

QQ39–42 *The Committee wished to receive information on the percentage of live births which have been submitted for the maternity HES data for each region for 1991.*

A table showing the estimated percentage of live births which were submitted on HES for each RHA in 1991–92 is attached at Table 1.

Q74 *Mrs Butler undertook to give a more detailed description of the changes to PSS data to reflect community care changes.*

Following the Department of Health's Personal Social Services Information Strategy new statistical returns have been developed and some existing returns are being revised to cover what were perceived to be significant gaps in current collections. These changes are largely based on the need, following "Caring for People", for more client-orientated data and the extension of coverage to incorporate services which local authorities contract to the independent sector.

Information is to be collected for *day and domiciliary services* provided under contract by the voluntary and private sector where previously information was only available for services provided directly by the LA. Data on home help/home care services to clients is being collected for the first time.

The *residential accommodation* returns are also to be revised to take account of the community care changes in particular to reflect the new funding arrangements.

A *summary of the main changes* is attached at Annex C. *Details of the data collections* are at annexes D and E. The Committee may be interested to know that improvement of central returns is on-going. Consequently, the day and domiciliary returns for 1993 will differ slightly from the 1992 returns.

Q77 *Has the Department established whether destination on discharge data is collected in Wales, and what are the implications for England?*

The information collected on English HES on destination on discharge is shown at Annex F. The same information is collected in Wales.

Q84 *Which areas are piloting the collection of ethnic origin data?*

The collection of Ethnic Origin data was piloted at:

(a) The United Bristol Healthcare Trust (Bristol)

(b) St. Mary's Hospital (Manchester).

ANNEX A

Uses made of information collected centrally from the NHS

KA Returns—Patient Transport

KA32—**Patient Transport Services:** Summary of Patient Journeys.

Major users: FCIA, FCIA-FAST, PMD ASPU.

Total journeys are required for the cost-weighted activity index and for Departmental accountability. It will be reviewed in the light of the proposed CMDS for ambulance services.

Used in DH statistical publication: "Patient transport services".

Used within Health Service Indicators.

Under review.

KA34—**Patient Transport Services:** Quality of Service Return.

Major users: PMD-ASPU.

This information is essential to monitor response time standards as stated in the Patient's Charter and HSG(91)29: "Ambulance and other patient transport services—operation, use and performance standards". It will be reviewed in the light of the proposed CMDS for ambulance services.

Used in DH statistical publication: "Patient transport services".

Used within Health Service Indicators.

Under review.

KC Returns—Community

KC50—**Immunisation Programmes:** District Activity;

KC50A—**Immunisation Programmes:** District Activity; and

KC51—**Immunisation Status of District Residents.**

Major users: HP(A)3, HP(M)1.

Information on immunisation is essential for monitoring the childhood immunisation programme. The Health of the Nation White Paper confirmed new targets for childhood immunisation (95 per cent cover by 1995). These returns provide accurate information on vaccination uptake to assess progress and to take action if necessary.

Used in DH statistical publication: "Immunisation programmes";

Used within Health Service Indicators (KC51).

Under review.

KC53—**Adult Screening Programmes:** Cervical Cytology; and

KC61—**Pathology Laboratories:** Cervical Cytology and Biopsies.

Major users: FCIA, FCIA-FAST, HCD-PH, HP(M)CHMU, NUR-HSSG, PMD-ASPU.

These returns are vital to monitor the process of achieving the Health of the Nation screening programme targets and 1993-94 NHS Priorities. The information is used in implementing paragraph B.12 of the Health of the Nation White Paper, which states that "the Government believes that the priority for this area should be the continued development of good practice in operating the screening, and in encouraging women to be screened". The information is essential to ensure that the programme is managed effectively and to identify regional variations and pursue shortcomings with the Regions. Totals are also required for the cost-weighted activity index (for PES and weighted capitation) and is important for Departmental accountability.

Used in DH statistical publication: "Cervical cytology screening".

Used within Health Service Indicators (KC53).

Under review.

KC54—**Professional Advice and Support Programmes:** Maternity Services.

Major users: FCIA, FCIA-FAST, NUR-HSSG, HP(A)3, HP(M)6.

Total contacts are required for the cost-weighted activity index (for PES and weighted capitation) and for Departmental accountability.

Used in DH statistical publication: "Maternity services: midwife clinics and domiciliary visits".

Under review.

KC55—**Professional Advice and Support Programmes:** Other than Maternity Services.

Major users: FCIA, FCIA-FAST, NUR-HSSG.

Parts of this return are used in the calculation of spending per head by age and the cost-weighted activity index (used in PES and weighted capitation). It is also required for Departmental accountability.

Used in DH statistical publication: "Health visitor activity".

Used within Health Service Indicators.

Under review.

KC56—**Patient Care in the Community:** District Nurses.

Major users: CS4, FCIA, FCIA-FAST, HC(M)2, PMD-CU.

This is needed for implementation of Caring for People and Care in the Community. Parts of this return are used in the calculation of spending per head by age and the cost-weighted activity index (used in PES and weighted captitation). It is also required for Departmental accountability.

Used in DH statistical publication: "District nurses activity".

Used within Health Service Indicators.

Under review.

KC57—**Patient Care in the Community:** Community Psychiatric Nurses.

Major users: CS4, FCIA, FCIA-FAST, HC(A)3, HC(M)2, NUR-HSSG, PMD-CU.

This is required for implementation and monitoring of Community Care reforms and policy analysis. Parts of the return are used in the calculation of spending per head by age and the cost-weighted activity index (used in PES and weighted capitation). It is also required for Departmental accountability.

Used in DH statistical publication: "Community psychiatric nurses activity".

Used within Health Service Indicators.

Under review.

KC58—**Patient Care in the Community:** Community Mental Handicap Nurses.

Major users: CS4, FCIA, FCIA-FAST, HC(A)3, HC(M)2, NUR-HSSG, PMD-CU.

This is required for implementation and monitoring of Community Care reforms and policy analysis. Parts of the return are used in the calculation of spending per head by age and the cost-weighted activity index (used in PES and weighted capitation). It is also required for Departmental accountability.

Used in DH statistical publication: "Community mental handicap nurses activity".

Under review.

KC59—**Patient Care in the Community:** Nurses other than District Nurses, Community Psychiatric Nurses and Community Mental Handicap Nurses.

Major users: CS4, FCIA, FCIA-FAST, HC(M)2, PMD-CU.

This is required for implementation and monitoring of Community Care reforms. Parts of the return are used in the calculation of spending per head by age and the cost-weighted activity index (used in PES and weighted capitation). It is also required for Departmental accountability.

Used in DH statistical publication: "Community psychiatric nurses activity".

Under review.

KC60—**Genito-Urinary Medicine Clinics:** Cases of Sexually Transmitted Diseases.

Major users: AIDS UNIT, HCD-PH, HP(A)3, HP(M)1, HP(M)CHMU.

This information is vital to monitor Health of the Nation targets. The information is used in monitoring reported cases of gonorrhoea (target D1) and more generally in implementing objectives related to sexual activity (reducing the incidence of HIV and other sexually transmitted diseases, developing further and strengthening monitoring and surveillance and providing effective services for diagnosis and treatment of HIV and other sexually transmitted diseases).

Used in DH statistical publication: "Genito-urinary medicine clinics, new cases seen".

KC62—**Adult Screening Programme:** Breast Cancer Screening (Screening Centre); and

KC63—**Adult Screening Programme:** Breast Cancer (District).

Major users: FCIA, HCD-PH, HP(M)CHMU, NUR–HSSG, PMD–ASPU.

These returns are vital to monitor the process of achieving the Health of the Nation screening programme targets and 1993–94 NHS Priorities. The information is used in implementing paragraph B.8 of the Health of the Nation White Paper, which states that "the Government believes that the priority for this area should be the maintenance of the high standards achieved so far in the programme, and the encouragement of women to take up screening invitations". The information is essential to ensure that the programme is managed effectively and to identify regional variations and pursue shortcomings with the Regions. Most of the information on KC62 is required by the Cancer Screening Evaluation Unit. Information on these returns is also important for Departmental accountability.

Used in DH statistical publication: "Breast cancer screening".

Under review.

KC64—**Community Health Services:** Dental Activity.

Major users: DEN, F2, P1.

This return is needed to ensure the protection, promotion and improvement of the health of the nation. It is used to pursue strategic and charging policies, and provides information on safety of anaesthetics. It also contains information essential to ensure that value for money is being achieved.

Under review.

KE Returns—Estates

KE81—**(Non-residential) Property Transactions**

Major users: FCIA, FCIA-FAST, NHSE1.

This return identifies changes in property holdings. It is an indicator of rationalisation. Regional figures are needed for PES and for Departmental accountability.

Under review.

KE84—**Estate Stock**

Major users: FCIA, FCIA-FAST, NHSE1

This return identifies, by site, land area, building area, area surplus to requirements, physical condition, statutory and safety compliance, energy performance and space utilisation. It indicates the potential for estates rationalisation and eradication or repair backlog. It measures achievement by comparing yearly returns. Regional and National figures are needed for PES and for Departmental accountability.

Used within Health Service Indicators.

Under review.

KE85—**Estate Finance/Budgets.**

Major users: FCIA, NHSE1.

This return shows expenditure on upgrading, capital works and other estate expenditure. It is a measure, with KE84, of whether or not capital asset management is effective, and is needed for Departmental accountability.

Under review.

KE86—**Energy and Utility Consumption.**

Major users: FCIA, NHSE1.

This return records usage and energy saving measures. The information is needed to monitor performance against provider unit targets set to achieve, by April 1996, an overall reduction of 15 per cent in energy consumption. [EL(92) 47 para C4] It is important for Departmental accountability.

Used within Health Service Indicators.

Under review.

KH RETURNS—HOSPITAL ACTIVITY

KH02—**Summary of Private Beds.**

Major users: CA–IU, CA–OPU, FCIA.

There is a Statutory requirement to collect this information centrally. The return provides an indication of NHS facilities devoted to private patients. Information is being collected on this form for 1992-93 but will be collected from other financial returns from 1993-94.

Under review.

KH03—**Summary of Bed Availability.**

Major users: FCIA, HC(A)1, HC(A)2, HC(M)1, HP(A)3, HP(M)5, PMD–ASPU.

This is used to calculate throughput and measures of efficiency and service provision, and is needed for Departmental accountability.

Used in DH statistical publications: "NHS Hospital Activity Statistics"; "Summary of bed availability"; "Health and Personal Social Services statistics".

Under review.

KH05—**Summary of Ward Attenders.**

Major users: FCIA, FCIA-FAST, HC(A)2, HC(M)1, HP(M)5.

This is used as a measure of essential hospital activity in relation to children. Total attendances are required for the cost-weighted activity index and for Departmental accountability.

Used in DH statistical publications: "NHS Hospital Activity Statistics"; "Outpatient and ward attenders".

Under review.

KH06—**Demand for Elective Admission:** Events occurring during the Quarter (Provider Based);

KH06R—**Demand for Elective Admission:** Events occurring during the Quarter (Resident Based);

KH07—**Demand for Elective Admission:** Position at the end of the Quarter (Provider Based);

KH07R—**Demand for Elective Admission:** Position at the end of the Quarter (Resident Based);

KH07A—**Demand for Elective Admission:** Number of People who have Deferred Admission Waiting at the End of the Quarter (Provider Based);

KH07AR—**Demand for Elective Admission:** Number of People who have Deferred Admission Waiting at the End of the Quarter (Resident Based); and

MA02—**Provider Waiting Times.**

Major users: HC(M)1, PMD-WTU.

This information is used in interpreting the current trends which feature prominently in the development of policy, PES negotiations and performance management.

Used in DH statistical publications: "Elective Admissions and Patients Waiting" (KH06, KH07); "Health and Personal Social Services statistics" (KH07, KH07A).

Under review.

KH08—**NHS Operating Theatres:** Availability and Use.

Major users: FCIA, HC(M)1, PMD-ASPU.

The return provides essential information used to monitor standards of performance and the availability and use of operating theatres. It is needed for public accountability.

Used in DH statistical publications: "NHS Hospital Activity Statistics"; "NHS operating theatres: availability and use"; "Health and Personal Social Services statistics".

Used within Health Service Indicators.

Under review.

KH09—**Consultant Outpatient Clinic Activity and Accident and Emergency Services Activity.**

Major users: PMD-ASPU, PMD-CU.

This provides a breakdown of two key areas of HCHS activity, outpatients and accident and emergency attendances, by district, and is used in performance management.

Used in DH statistical publications: "NHS Hospital Activity Statistics"; "Outpatient and ward attenders"; "Health and Personal Social Services statistics".

Used within Health Service Indicators.

Under review.

KH10—**Summary of Radiotherapy Machine Activity;**

KH11—**Diagnostic Departments:** Pathology;

KH12—**Diagnostic Departments:** Radiology, Nuclear Medicine and Medical Physics; and

KH13—**Diagnostic Departments:** Physiological Measurements.

Major users: CA-OPU, FCIA, HC(M)1.

Some of this information contributes to securing high quality health care through the NHS and some is used very regularly to answer PQs and other information requests. Information on KH12 tracks population exposure to medical ionising radiation.

Figures from KH10 were given in the CMO's most recent report.

KH11 is needed for Departmental accountability.

Used within Health Service Indicators (KH10, KH12).

Under review.

KH14—**NHS Day Care:** Availability and Use of Facilities.

Major users: FCIA, FCIA-FAST, HC(A)1, HC(A)3, HC(M)2, HP(A)2.

This is used in policy analysis and to monitor Care in the Community reforms. Total attendances are required for the cost-weighted activity index and for Departmental accountability.

Used in DH statistical publication: "NHS Day care facilities".

Used within Health Service Indicators.

Under Review.

KH15—**Legal Status of Patients:** Legal Status on Admission;

and

KH16—**Legal Status of Patients:** Number of Changes in Legal Status.

Major users: HC(A)1, HC(M)2, NUR-HSSG.

This information is used to monitor the use of the Mental Health Act 1983: "The Secretary of State shall keep under review the exercise of the powers and the discharge of the duties conferred or imposed by this Act so far as relating to the detention of patients or to patients liable to be detained under this Act". It provides key indicators for monitoring policy implementation re the Reed Committee (and National Committee to oversee), and mental health policy. This information will also be used to help establish performance indicators for these activities.

Used in DH statistical publication: "In-patients formally detained in hospital under the Mental Health Act 1983 and other legislation".

Under review.

KM Returns—Manpower

KM48—**Joiners and Leavers Data:** Summary of Total Staff Flow.

Major users: HAP1, HAP3, HAP4, HAP(STATS), NUR–ME.

This is a replacement return to monitor recruitment to and leavers from the NHS (Working Paper 10 groups only). The information will be used to support policy development on recruitment (including re-entrants) and retention.

Additionally the return will provide recruitment, turnover and wastage information in support of the Pay Review Body and Whitley Council pay determination process.

To be used in DH statistical publications: "NHS Workforce in England (Blue Book)"; "Statistical Bulletin on Non-medical Workforce".

Under review.

KO Returns—Miscellaneous

KO36—**Private Hospitals, Homes and Clinics Registered Under Section 23 of the Registered Homes Act 1984.**

Major users: CA–IU, CA–OPU, CS4, FCIA, NUR–HSSG, PMD–CU.

This information is needed to monitor the effects of the Community Care reforms. It allows the Department to monitor the change in the source of public funding for nursing home provision from April 1993. It is also needed for Departmental acountability.

Used in DH statistical publication: "Private hospitals, homes and clinics registered under section 23 of the Registered Homes Act 1984".

Under review.

KO37—**Registered Homes Act 1984 (Section 23);** Mental Nursing Homes authorised to detain patients; not covered by contractual arrangements.

Major users: HC(A)1, HC(M)2, NUR–HSSG.

This return monitors the use of the Mental Health Act 1983. It shows the legal status of patients admitted to private mental nursing homes. When linked with information on NHS provision from KH15 abd KH16 and on SHSA provision, this provides a comprehensive count of the legal status of patients and trends.

Used in DH statistical publication: "In-patients formally detained in hospital under the Mental Health Act 1983 and other legislation".

Under review.

KO39—**Hospital Eye Service.**

Major users: FCIA, HC(M)1, PMD–ASPU.

This return is needed (with information on the use of vouchers issued) in order to cost the voucher scheme. It is also needed for Departmental accountability.

Under review.

KO40—**Return of Written Complaints by or on Behalf of Patients.**

Major users: CF–ME, HC(M)1.

The Prime Minister attaches great importance to the Citizen's Charter. Under this the Department is expected to be able to demonstrate that the NHS has learnt from the complaints received, and the public should receive information about the outcome of complaints so that they can have confidence that it is worth complaining.

Under review.

KO71—**Drug Agencies Return.**

Major users: HP(A)2, HP(M)4.

The Government attaches a high priority to tackling drug misuse. Because of its illicit nature there is limited information available on its extent and the appropriate scale of service response. The Department needs access to this information to ensure that policy objectives are being met.

KO73—**Wheelchairs and Artificial Limbs.**

Major users: FCIA, HC(A)2.

This return is needed to monitor the Community Care reforms and the development of services for disabled people, which have recently come under detailed scrutiny from the House of Commons Public Accounts Committee.

KO74—**Health Activity Supplied to a District's Residents.**

Major users: FCIA, SD2.

This is a new return providing bottom-line counts of activity purchased for districts' residents (indicating type of purchaser, type of provider and service). The information is vital to the development of purchaser monitoring, and is used for grossing HES. It is also needed for Departmental accountability.

KP Returns—Hospital Statistics

KP70—**Summary Return of Patient Activity.**

Major users: FCIA, PMD–ASPU, PMD–CU.

This return provides key indicators of provider activity (finished consultant episodes and deliveries) by speciality. These are vital to policy development and have recently been used in areas of major importance such as Patient's Charter and the Tomlinson enquiry into London's health services. This information is also needed for Departmental accountability. Figures are used as grossing factors for HES data.

Used in DH statistical publications: "NHS Hospital Activity Statistics"; "Ordinary admissions, day case admissions and regular day and night admissions"; "Health and Personal Social Services statistics".

KT Returns—Paramedical

KT23—**Summary of Chiropody Services.**

Major users: CS4, FCIA, FCIA-FAST, HC(M)1, HEF(A)4.

This information is needed to assist in developing and monitoring the delivery of chiropody services in the NHS. It is strongly connected with community care of the elderly. It is also used for the cost-weighted activity index (for PES and weighted capitation) and Departmental accountability.

Used in DH statistical publication: "Chiropody services".

Used within Health Service Indicators.

Under review.

KT24—**Summary of Clinical Psychology Services.**

Major users: HC(A)1, HC(A)3, HC(M)2, NUR-HSSG.

This is used for policy analysis. Part of the information collected is needed for the Health of the Nation Mental Illness key area: Paragraph C.16 of Health of the Nation White Paper identifies the need for "continued development and improvements in comprehensive local services for all mental illness".

Used in DH statistical publication: "Clinical psychology services".

Used within Health Service Indicators.

Under review.

KT25—**Summary of Dietetic Services.**

Major users: HEF(A)4, HEF(M)2.

This return is needed in a modified form to monitor activity which contributes to achieving Health of the Nation targets.

Used in DH statistical publication: "Dietetic services".

Under review.

KT26—**Summary of Occupational Therapy Services;** and

KT29—**Summary of Speech Therapy Services.**

Major users: FCIA, HC(A)2, HC(M)2.

These returns are required to monitor progress on Ministers' policy for the development of rehabilitation services and, in particular, its progress towards Health of the Nation key area status and the development and subsequent monitoring of appropriate targets. They are also needed for Departmental accountability.

Used in DH statistical publication: "Occupational therapy services" (KT26); "Speech therapy services" (KT29); Used within Health Service Indicators.

Under review.

KT27—**Summary of Physiotherapy Services.**

Major users: CS4, FCIA, HC(A)2, HC(M)2.

This is required to monitor progress with Ministers' policy on the development of rehabilitation services, and in particular in its progress towards Health of the Nation key area status and the development and subsequent monitoring of appropriate Health of the Nation targets. It is strongly linked to community care of the elderly, the physically disabled and those with learning disabilities. It is also needed for Departmental accountability.

Used in DH statistical publication: "Physiotherapy services".

Used within Health Service Indicators.

Under review.

KT31—**Summary of Family Planning Activities.**

Major users: FCIA, FCIA–FAST, HP(A)3, HP(M)6, HP(M)CHMU, NUR–HSSG.

This information is required for monitoring the Health of the Nation objective "to ensure the provision of effective family planning services for those people who want them". Parts of the return are used in the calculation of spending per head by age and the cost-weighted activity index (used in PES and weighted capitation). It is also needed for Departmental accountability.

Used in DH statistical publication: "Family planning clinic services".

SBH RETURNS—CHRONICALLY SICK AND DISABLED

SBH179—**Chronically Sick and Disabled Persons Act 1970:** Return under Section 17(2).

Major users: HC(A)2.

There is a Statutory requirement to collect this information centrally.

Used in DH statistical publication: "Section 17(3) of the Chronically Sick and Disabled Persons Act, 1970".

HFR/TFR RETURNS—FINANCIAL

HFR7/TFR8—**Annual Cost:** Catering, laundry and linen services.

Major users: CA–OPU, FCIA.

This provides information to ensure financial accountability for these services and to monitor their cost-effectiveness. It is also needed for Departmental accountability.

HFR16/TFR6—**Patient Transport Services.**

Major users: PMD–ASPU, FCIA.

This provides information to ensure the financial accountability of ambulance services and to monitor their cost-effectiveness. It is also needed for Departmental accountability.

Used within Health Service Indicators.

HFR20—**Joint Finance and Care in the Community.**

Major users: CS4, FCIA.

This is essential for monitoring the use of special top-sliced allocations, and for Departmental accountability.

HFR21/TFR1—**Hospital and Community Health Services:** Departmental Analysis; and HFR22/TFR2—**Specialty and Programme Costs;**

Major users: EOR1, EOR3, FCIA, FCIA–FAST.

These are used in the programme budget analysis to assess trends in HCHS spending by sector. They are a key input into further analyses used for PES and weighted capitation, and are needed for Departmental accountability. They have been used in other important analyses including the Tomlinson review of London's health services, review of SIFTR, and internal market allocations for the SHAs.

Used within Health Service Indicators.

Under review.

HFR23—**Administration and Purchasing Expenses.**

Major users: FCIA, FCIA–FAST, PMD–CU.

This return provides information to ensure the financial accountability of health authorities and, for monitoring purposes, to profile their expenditure on administration, services and the purchase of health care. It is also needed for Departmental accountability.

HFR24—**Care Group Analysis of Health Services Purchased.**

Major users: FCIA, FCIA–FAST, HC(A)1.

This is used in the programme budget analysis to assess trends in HCHS spending by sector. It is a key input into further analyses used for PES and weighted capitation, and is needed for Departmental accountability.

Under review.

HFR25/TFR3—**Analysis of Expenditure by Type.**

Major users: FCIA, FCIA–FAST, FCIA–RAFT, HAP(STATS).

This information is used for pay and price indices and is included in Banking Stewardship reports to the Treasury.

Used within Health Service Indicators.

HFR28—**Artificial Limb and Wheelchair Services.**

Major users: FCIA, HC(A)2.

This is used to identify areas where corrective action with regard to services offered is required, and is required for Departmental accountability.

QM Returns—Quarterly Monitoring

QM01—**Purchaser Activity;** and

QM01A—**GP Fundholder Activity.**

Major users: FCIA, FCIB–MIAB, PMD–CU.

These returns provide the only means of in-year monitoring of NHS activity. The information is essential in assessing progress towards activity targets agreed in Corporate Contracts. It forms the basis of the CE's regional reviews and quarterly reports to the ME and Policy Board.

QM02—**General Medical Services Activity.**

Major users: FCIA, FCIB–MIAB, PMD–CU, HCD–SD1.

These returns provide the best means of conducting in-year monitoring of primary health care activity. The information is essential in monitoring activity against expectations agreed in Corporate Contracts. It is used to evaluate regional performance and query activity levels. It forms the basis of the CE's regional reviews and quarterly reports to the ME and Policy Board.

QM03—**Non-provider Manpower.**

Major users: CSO.

The Central Statistics Office (CSO) requires this information for National Accounts purposes. The information also contributes to the Employment Department's quarterly estimates of the number of jobs at both national and regional level. The NHS is of vital importance: it accounts for no less than six per cent of all employees in Great Britain.

Under review.

QM05—**Provider Activity.**

Major users: FCIA, FCIB–MIAB, PMD–CU.

These returns provide the only means of in-year monitoring of provider activity. This information is essential for monitoring performance against Corporate Contracts and Trust business plans. It forms the basis of the CE's regional reviews and quarterly reports to the ME and Policy Board. It has been used for answering Parliamentary Questions and is the basis for ME publications such as the Chief Executive's and the Departmental Annual reports, and for evidence to Select Committees.

QM06—**Provider Manpower.**

Major users: CSO.

The CSO requires this information for National Accounts purposes.

Under review.

Patient's Charter Returns

Major users: CF–ME, PMD–CU.

Vital to monitor the delivery of Rights and Standards to patients, to take management action where necessary, and to develop policy.

Under review.

GLOSSARY OF TERMS AND ABBREVIATIONS USED IN THIS DOCUMENT

Directorates/Divisions/Branches

CA–IU	Corporate Affairs Directorate—Intelligence Unit
CA–OPU	Corporate Affairs Directorate—Operational Policy Unit
CF–ME	Consumer Focus Branch—NHS Management Executive (Corporate Affairs Directorate)
CS	Community Services Division

DEN	Dental Division
DM	Departmental Management
DRS	Departmental Resources Services Group
EOR	Economics and Operational Research Division
F	Finance
FCIA–FAST	Finance and Corporate Information Directorate Division A—Financial Analysis and Survey Team
FCIA–RAFT	Finance and Corporate Information Directorate Division A—Resource Allocation and Funding Team
FCIB–MIAB	Finance and Corporate Information Directorate Division B—Management Information and Analysis Bureau
HAP	Health Authority Personnel Division
HAP (STATS)	Health Authority Personnel Division (Statistics Branch)
HC(A)	Health Care (Administrative) Division
HC(M)	Health Care (Medical) Division
HCD–PH	Health Care Directorate—Public Health Division
HCD–SD	Health Care Directorate—Services Development Division
HEF(A)	Health aspects of the Environment and Food (Administrative) Division
HEF(M)	Health aspects of the Environment and Food (Medical) Division
HP(A)	Health Promotion (Administrative) Division
HP(M)	Health Promotion (Medical) Division
HP(M) CHMU	Health Promotion (Medical) Division Central Health Monitoring Unit
IMGME	Information Management Group of the NHS Management Executive
ISD	Information Systems Directorate
NUR–HSSG	Nursing Division—Health and Social Services Group
NUR–ME	Nursing Directorate—NHS Management Executive
P	Family Health Services Division
PMD–ASPU	Performance Management Directorate—Acute Services Policy Unit
PMD–CU	Performance Management Directorate—Central Unit
PMD–WTU	Performance Management Directorate—Waiting Time Unit
SD	Statistics Division

Other Abbreviations

CE	Chief Executive of the NHS Management Executive
CMDS	Contract Minimum Data Set
CMO	Chief Medical Officer
CSO	Central Statistical Office
DCMO	Deputy Chief Medical Officer
DDN	Deputy Director of Nursing
DH	Department of Health
EL	Executive Letter
HIV	Human Immunodeficiency Virus
HCHS	Hospital and Community Health Services
HES	Hospital Episode Statistics
HSG	Health Service Guidelines
ME	NHS Management Executive
NHSE	NHS Estates Agency
PES	Public Expenditure Survey (the annual process of negotiating with Treasury for funds)
PQ	Parliamentary Question
SHSA	Special Hospital Services Authority

Terms

Cost-Weighted Activity Index	an overall measure of HCHS activity trends used to demonstrate efficiency gains in PES negotiations, to the Select Committee on Health, etc.
Weighted Capitation	a formula for allocating funds for HCHS within the NHS, to provide for Health Authorities to commission similar levels of health services for resident populations at similar risk.

ANNEX B

Hospital Episode Statistics—'Maternity Tail'

Title	*HES Field No.*	*HES Field Name*	*Page*
Data about Delivery (from birth notification)			
Anaesthetic given post delivery	51	DELPOSAN	D1/13
Anaesthetic given during labour/delivery	50	DELPREAN	D1/13
Birth date of baby	58	DOBBABY	D1/17
Birth date of mother	59	MOTDOB	D1/27
Birth weight	56	BIRWEIT	D1/4
Birth order	54	BIRORDER	D1/3
Delivery place change reason	45	DELCHANG	D1/9
Delivery place type	43	DELPLACE	D1/12
Delivery method	48	DELMETH	D1/11
First antenatal assessment date	41	ANASDATE	D1/2
Initial intended delivery place type	44	DELINTEN	D1/9
Labour/delivery onset method	47	DELONSET	D1/12
Length of gestation	46	GESTAT	D1/19
Live or still birth	55	BIRSTATE	D1/4
Number of babies	52	NUMBBABY	D1/27
Pregnancy: total previous pregnancies	42	NUMPREG	D1/28
Resuscitation: Positive Pressure method	57	BIRRESUS	D1/3
Sex of baby	53	SEXBABY	D1/30
Status of person conducting delivery	49	DELSTAT	D1/14

ANASDATE **First antenatal assessment date**

The date on which the pregnant woman was first assessed and arrangements were made for antenatal care. This is not necessarily the occasion on which arrangements were made for delivery.

Code	Classification
ddmmyy	dd = day of date (01—31) mm = month of date (01—12) yy = year of date (00—Current year)
—spaces	Not applicable (ie no antenatal assessment made)
&spaces	Not known

BIRORDER **Birth order***

The sequence in which the baby was born, if part of a delivery having multiple births. In the case of multiple birth, it is the position of this birth in the sequence.

Code	Classification
1	First
2	Second
3	Third
4	Fourth
5	Fifth
6	Sixth
—	Not applicable (ie singleton)

Note to reviewers: it has been pointed out that this in not consistent with NUMBBABY in which the code 6 indicates 6 or more babies).

BIRRESUS **Resuscitation: Positive Pressure method**

The means by which regular respiration of the baby was attempted. This is not recorded for still births. For local purposes, the actual drugs administered should be specified.

Code	Classification
1	Positive pressure nil, drugs nil
2	Positive pressure nil, drugs administered
3	Positive pressure by mask, drugs nil
4	Positive pressure by mask, drugs administered

Code	Classification
5	Positive pressure by endotracheal tube, drugs nil
6	Positive pressure by endotracheal tube, drugs administered
&	Not known
—	Not applicable (ie stillborn, where no method of resuscitation was attempted

BIRSTATE **Live or still birth**

An indicator of whether the birth was a live or a still birth. A still birth is a birth after a gestation of 24 weeks (168 days) where the baby shows no identifiable signs of life at delivery. Up to and including 30 September 1992, the criterion was 28 weeks, not 24 weeks as above.

Code	Classification
1	Live
2	Still birth, ante-partum
3	Still birth, intra-partum
4	Still birth, indeterminate

BIRWEIT **Birth weight**

Code	Classification
nnnn	0001—6999 grammes
7000	7000 grammes or greater
&spaces	Not known

CATEGORY **Category of patient***

The administrative and legal status of the patient

Code	Classification
10	NHS Patient—not formally detained
11	NHS Patient—formally detained under Part II, Mental Health Act 1983
12	NHS Patient—formally detained under Part III, Mental Health Act 1983 or under other Acts
20	Private Patient—not formally detained
21	Private Patient—formally detained under Part II, Mental Health Act 1983
22	Private Patient—formally detained under Part III, Mental Health Act 1983 or under other Acts
30	Amenity Patient—not formally detained
31	Amenity Patient—formally detained under Part II, Mental Health Act 1983
32	Amenity Patient—formally detained under Part III, Mental Health Act 1983 or under other Acts
Spaces	*Other Maternity event*

DELMETH **Delivery method**

The method by which a woman is delivered of a baby which is a Registrable Birth.

The following list contains more detail than the Minimum Data Set Model Classification but aligns with it.

Code	Classification
0	Normal (spontaneous, vertex, vaginal delivery, occipitoanterior)
1	Spontaneous, other cephalic
	Cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation
2	Low forceps, not breech
	eg forceps, low application, without manipulation
	Forceps delivery not otherwise specified
3	Other forceps, not breech
	eg forceps with manipulation
	High forceps
	Mid forceps
4	Ventouse, vacuum extraction
5	Breech delivery, spontaneous, assisted or unspecified
	Partial breech extraction
6	Breech extraction:
	Not otherwise specified

Code	Classification
	Total breech extraction
	Version with breech extraction
7	Elective Caesarean section
	Caesarean section before, or at onset of, labour
8	Emergency Caesarean section
9	Other than those specified above
	eg application of weight to leg in breech delivery
	Destructive operation to facilitate delivery
	Other surgical or instrumental delivery
&	Not known ie unspecified

These relate to the ICD–9 Classification for abbreviated Delivery method, which may be found after ICD 6699 in ICD–9 Volume I.

DELONSET **Labour/delivery onset method**

Methods used to induce rather than to accelerate labour.

Code	Classification
1	Spontaneous, the onset of regular contractions whether or not preceded by spontaneous rupture of the membranes
2	Elective Caesarean section, carried out before the onset of labour, or in the case of a planned elective operation, immediately following the onset of labour when the decision was made before labour
3	Surgical induction, by amniotomy
4	Oxytocic drugs, including the administration of agents either orally, intravenously or intravaginally with the intention of initiating labour
5	Combination of surgical induction and oxytocic drugs
&	Not known

(Note to reviewers: It has been pointed out that there is a difference relating to Caesarean sections—if the MDSM classification is used for hospital recording, there is no way code 2 can be achieved for HES).

DELPLACE (DELINTEN) **Delivery place type**

Used to classify initial intention and actual place of delivery. The initial intention for place of delivery is that designated by the General Medical Practitioner and midwife or by the General Medical Practitioner and hospital staff. The decision is normally made when the mother is assessed for delivery and, as a result of this, formal arrangements are made. DELINTEN is the initial intention for place of delivery, DELPLACE is the actual type of premises in which delivery took place.

Code	Classification
1	At a domestic address
2	In NHS hospital—delivery facilities associated with consultant ward
3	In NHS hospital—delivery facilities associated with GMP ward
4	In NHS hospital—delivery facilities associated with consultant/GMP ward
5	In private hospital
6	In hospital or institution
7	In NHS hospital—ward or unit without delivery facilities
8	Other, ie none of the above
&	Not known

DELPOSAN (DELPREAN) **Anaesthetic given post delivery***

This records the anaesthesia/analgesia administered during and after labour and delivery. The anaesthetic clinical option expands on the classification. DELPOSAN is anaesthesia or analgesic administered post delivery. DELPREAN is anaesthesia or analgesia administered before and during labour and delivery.

Code	Classification
1	General anaesthesia, the administration by a doctor of an agent intended to produce unconsciousness
2	Epidural or caudal anaesthesia, the injection of a local anaesthetic agent into the epidural space

Code	Classification
3	Spinal anaesthesia, the injection of a local anaesthetic agent into the subarachnoid space
4	General anaesthesia and epidural or caudal anaesthesia
5	General anaesthesia and spinal anaesthesia
6	Epidural or caudal and spinal anaesthesia
8	Other than 1 to 6
—	No analgesia or anaesthesia administered
&	Not known

Note that the contract codes are different for these data items (see Section A1, Technical Module (Volume 1)).

DELPREAN **Anaesthetic given during labour/delivery***

See DELPOSAN for codes and classifications.

DELSTAT **Status of person conducting delivery**

This is normally the status of the individual who delivers the baby. When delivery is carried out by a student, the individual supervising the delivery should be the one recorded as conducting it. This may be different for each birth in a multiple birth.

Code	Classification
1	Hospital doctor
2	General practitioner
3	Midwife
8	Other than above
&	Not known

DOBBABY (MOTDOB) **Birth date of baby**

Code	Classification
ddmmyy	dd = day of birth (01-31) mm = month of birth (01-12) yy = year of birth (00-current year)
&spaces	Not known (only acceptable for *Other delivery events* which are not in the category, Intended Home Births)

GESTAT **LENGTH OF GESTATION**

Code	Classification
nn	10-49 in weeks
&space	Not known

MOTDOB (DOBBABY) **Birth date of mother**

See DOBBABY for codes and classifications.

NUMBBABY **Number of babies***

Code	Classification
1	One
2	Two
3	Three
4	Four
5	Five
6	Six or more

NUMPREG **Pregnancy: total previous pregnancies**

Code	Classification
nn	nn = 00-19

Code	Classification
00	No previous pregnancy resulting in a registrable birth
01	One previous pregnancy resulting in a registrable birth
02	Two previous pregnancies resulting in a registrable birth
03	Three previous pregnancies resulting in a registrable birth
04	Four previous pregnancies resulting in a registrable birth
05	Five previous pregnancies resulting in a registrable birth
06	Six previous pregnancies resulting in a registrable birth
etc, until,	
19	Nineteen previous pregnancies resulting in a registrable birth
&space	Not known

SEX (SEXBABY) **Sex**

Code	Classification
1	Male
2	Female
3	Indeterminate or anticipated sex change

SEX is the field name used generally, SEXBABY applies to babies.

Key:

* Items required in the Contract Minimum Data Set, or Central Returns, derived from Minimum Data Set Model items

Table 1

HES submissions in 1991–92 : Estimated coverage of Birth Episodes by region and England (excluding Special Health Authorities)

Regions	*Per cent of Birth Episodes*
Northern RHA	96 per cent
Yorkshire RHA	78 per cent
Trent RHA	87 per cent
East Anglian RHA	96 per cent
N. W. Thames RHA	75 per cent
N. E. Thames RHA	86 per cent
S. E. Thames RHA	86 per cent
S. W. Thames RHA	86 per cent
Wessex RHA	95 per cent
Oxford RHA	91 per cent
S. Western RHA	57 per cent
W. Midlands RHA	60 per cent
Mersey RHA	67 per cent
N.Western RHA	98 per cent
England	82 per cent

ANNEX C

SUMMARY OF MAIN CHANGES TO ADULT DAY/DOMICILIARY AND RESIDENTIAL RETURNS

Adult Day and Domiciliary Returns

The returns were introduced to cover a sample week in September 1992 and are to be repeated annually.

Day Care

The information on day centres has been extended to collect data for a sample week on:

— total attendances by client group (separately identifying attendances at mixed centres);

— meals served at day centres;

— number of hours of outreach by LA day centre staff, and

— centres open 7 days a week.

The information is collected on an aggregate return from each LA instead of a return from each centre.

Information is no longer collected on the number of places at 31 March but is instead collected on place-days during a sample week. This change was made to reflect the move away from a traditional "5 day a week" service to a more flexible "session-based" service. Information on place-days is collected by client group instead of by centre type.

Home help and home care services

Number information was collected by the Department on home help or home care services activity. Information is to be collected for a sample week on:

— total contact hours;

— number of households receiving services by client group and age;

— intensity of service (number of households receiving a total of x hours over y visits for different bands), and

— *from 1993* overnight services will be separately identified.

Meals service

The information collected on the meals service has been extended to collect information for a sample week:

— by provider (deliverer to home or server in luncheon club), by day of week (weekday, weekend) and location (at home or luncheon club)

— by provider by age of client and location

— *from 1993* information on sector preparing the meals will be collected in addition to sector serving or delivering meals.

The detail of the proposed changes to the returns on day and domiciliary care is at Annex D.

Residential Care

The revised returns are to be introduced for March 1994 to cover activity in 1993–94.

Supported residents

It is proposed that the information collected on supported residents in residential accommodation should be extended to:

— separately identify residential and nursing care;

— separately identify long stay and short stay residents;

— collect information on short stay admissions during the year by client group;

— include in the client group coverage drug and alcohol abusers and other client groups currently excluded and to separately identify elderly people from younger physically disabled people, and

— collect information on supported residents in unstaffed/group homes.

All residents in residential accommodation

It is proposed that information should be collected on admissions during the year to independent sector homes comparable with that currently collected from LA homes only. The Department is also considering the practicality of collecting information on independent sector group homes.

The detail of the proposed changes to the returns on residential care is at Annex E.

ANNEX D

New day and domiciliary services statistical returns

1. Three new returns have been introduced for a sample week in Autumn 1992 (28 September to 4 October). The intention is that this should be an annual exercise repeated each year for a sample week at around the same time.

2. All three returns only include services provided by the independent sector under contract. Where for example an organisation provides a service eg the WRVS meals or private domestic agencies that is not funded by a local authority this activity will be excluded from the returns.

Meals Service (MS1)

Number of meals provided during the week:
- by sector (LA, voluntary, private, NHS);
- by location (at home, luncheon club);
- by day of week (weekday, weekend);

Number of clients served with a meal during the week:
- by sector (LA, voluntary, private, NHS);
- by location (at home, luncheon club, and
- by age (18-64, 65-74, 75-84, 85+).

Home help or home care services (HH1)

Number of contact hours by sector.

Number of households who received services during the week:
- by sector (LA, voluntary, private);
- by client group (physical disabilities, PLD, MI, other), and
- by age (under 18, 18-64, 65+ and more detailed age breakdown of 65+: 65-74, 75-84, 85+ for all client groups);

Number of households who received services during the week:
- by sector (LA, voluntary, private);
- by no of visits (1, 2-5, 6-9, 10+), and
- by no (cumulative) of contact hours (>1, 1-2, 2-5, 5+) which gives an indication of intensity of service being provided.

Day Centres (DC3)

Number of Day Centres:
- by sector (LA, voluntary, private), and
- by type of centre (client group by age; separately identifies mixed centres);

Number of centres open seven days a week.

Number of place days during the week:
- by sector (LA, voluntary, private);
- by client group (physical disabilities, people with learning disabilities, mental illness, other), and
- by age (16-64, 65+).

Number of place days in centres open seven days a week.

Number of attendances (All centres) during the week:
- by sector (LA, voluntary, private);
- by client group (physical disabilities, PLD, MI, other), and
- by age (16-64, 65+; more detailed age breakdown of 65+: 65-74, 75-84, 85+ for all client groups).

Number of attendances at centres for mixed client groups during the week:
- by sector (LA, voluntary, private);
- by client group (physical disabilities, PLD, MI, other), and
- by age (16-64, 65+).

Number of attendances of people with learning disabilities at day centres during the week:
- by sector (LA, voluntary, private);
- by type of centre (Adult Training Centre, Independent Special Care Unit, SCU attached to ATC, others), and
- by age (16-64, 65+).

Number of meals provided:

by sector (LA, voluntary, private).

Number of hours of outreach services by LA staff during the week:

by client group (physical disabilities, PLD, MI, other), and

by age (16-64, 65+).

ANNEX E

New and revised statistical returns on residential accommodation

1. The current statistical returns which collect information on local authority supported residents and all residents are to be revised. New returns are to be introduced relating to 31 March 1994 activity during 1993—94. The proposed content of the new returns is set out below.

Local authority supported residents in residential accommodation

Number of local authority supported residents at 31 March

by client group (elderly, Younger Physically Disabled, people with learning disabilities, mental illness, other);

by type of care (residential, nursing);

by type of accommodation

((Residential: LA staffed, voluntary (registered), private (registered), other—excluding group homes))

((Nursing: Voluntary (dual), Voluntary (nursing), Private (dual), Private (nursing only));

by location (within LA, outside LA);

by age (under 18, 18-64, 65-74, 75-84, 85 or over), and

by type of stay (long stay, short stay).

Number of local authority supported residents in unstaffed (group) residential homes at 31 March:

by client group (elderly, YPD, PLD, MI, other);

by type of accommodation (LA, voluntary, private);

by location (within LA, outside LA), and

by age (under 18, 18-64, 65-74, 75-84, 85 or over).

Number of supported Adult placements at 31 March:

by type of stay (long stay, short stay) for:

(a) people with mental illness, and

(b) people with learning disabilities

Number of short stay admissions during the year:

by type of care (residential, nursing);

by client group (elderly, YPD, PLD, MI, other);

by type of accommodation

((Residential: LA staffed, voluntary (reg), private (reg), other))

((Nursing: Voluntary (dual), Voluntary (nursing only), Private (dual), Priv (nursing only));

by location (within LA, outside LA), and

by age (under 18, 18-64, 65-74, 75-84, 85 or over).

All residents in residential accommodation

For individual LA staffed and registered residential homes:

by sector (LA, voluntary, private), and

by primary function ie main client group.

Number of places at 31 March:

by type of care (residential, nursing), and

by type of room (single, double, multiple).

Number of residents at 31 March:
by type of care (residential, nursing);
by type of stay (long, short), and
by age (under 18, 18-64, 65-74, 75-84, 85 and over).
Number of admissions during the year:
by type of care (residential, nursing);
by type of stay (long, short), and
by age (under 18, 18-64, 65-74, 75-84, 85 and over).
Number of day care places available per day.
Number of days in week that day care is provided.
Attendances during the week of non-residents.

For individual Unstaffed (Group) residential homes:
by sector (LA, vol, private), and
by primary function ie main client group.
Number of places at 31 March.
Number of residents at 31 March.

ANNEX F

Hospital Episode Statistics—Destination on Discharge

DIAGNSIS Patient diagnosis/diagnostic codes

See Section D3. Technical Module (Volume II) for details

DISDATE Discharge date* (Hospital Provider Spell)

Date of discharge from hospital provider spell

Code	Classification
ddmmyy	dd = day of date (01 - 31) mm = month of date (01 - 12) yy = year of date (00 - current year)
-spaces	Not applicable (Hospital Provider Spell not yet finished)
spaces	*Other maternity event*

DISDEST Discharge destination* (Hospital Provider Spell)

The classification of where a patient is sent on completion of a hospital provider spell

Code	Classification
19	Usual place of residence, other than those institutions listed below (includes patients with no fixed abode)
29	Temporary place of residence, when usually resident elsewhere (includes hotels, residential educational establishments)
39	Penal establishment, court or police station
49	Special hospital +
51	Other NHS hospital provider—ward for general patients or the younger physically disabled or A&E department
52	Other NHS hospital provider—ward for maternity patients or neonates
53	Other NHS hospital provider—ward for patients who are mentally ill or who have learning disabilities (previously known as mental handicap)
54	Nursing Home, Residential Care Home or Group Home run by the NHS
69	Under Local Authority care (including residential accommodation and foster care)
079	Deaths, including still births
89	Non-NHS hospital, nursing home, health care or residential institution
-space	Not applicable (ie not discharged)
spaces	Not applicable (*Other maternity event*)

Key:

* Items required in the contract Minimum Data Set, or Central Returns, derived from Minimum Data Set Model items

ANNEX G

Maternity HES Data

1. The tables below show regional breakdowns of estimated percentages of some key data items relating to delivery episodes. All figures are rounded to the nearest whole number e.g. where 0 per cent is shown, this means less than 0.5 per cent. Where, because of poor data quality, it is not possible to produce reasonable estimates, this is signified by the symbol '-'. Where this occurs for the regional data within any category, it casts doubt on the region's data for other categories.

2. Table 1 shows estimated percentage relating to Place of Delivery. These estimates differ from OPCS birth registration data in that those data show two per cent of maternities being other than in a NHS hospital. It is thought that under-recording of home births within HES is the reason.

3. Table 2 shows estimated percentage relating to Method of Delivery.

4. Table 3 shows estimated percentages relating to Method of Onset of Labour.

5. Table 4 shows estimated percentages relating to Person Conducting Delivery.

6. Table 5 shows the mean and median Duration of Post-natal Stay.

TABLE 1

HOSPITAL EPISODE STATISTICS (MATERNITY) 1990–91 ENGLAND

Estimated Percentages: PLACE OF DELIVERY

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang*	*N.W. T.*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*	*SHA's*
All Places	100	100	100	100	100	100	100	100	100	100	100	—	—	100	100	100
In a Consultant ward	61	71	94	31	94	0	52	64	70	62	34	—	—	84	95	100
In a GP ward	3	1	4	3	4	0	5	0	1	9	5	—	—	1	3	0
Consultant/GP ward	35	27	2	65	0	99	42	35	29	27	60	—	—	15	2	0
Other than NHS hospital[1]	1	0	0	0	2	1	0	1	0	2	1	—	—	1	1	0

[1] This Line is an underestimate of the true position – see Notes.

TABLE 2

HOSPITAL EPISODE STATISTICS (MATERNITY) 1990–91 ENGLAND

Estimated Percentages: METHOD OF DELIVERY

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang*	*N.W. T.*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*	*SHA's*
All methods	100	100	100	100	100	100	100	100	100	100	100	—	—	100	100	100
Spontaneous	77	79	80	77	75	78	78	79	76	79	76	—	—	76	79	63
Instrumental	10	10	8	11	12	10	9	8	11	10	11	—	—	9	8	20
Caesarean	13	12	12	12	13	12	13	13	12	11	13	—	—	14	12	18
Other and unspecified	0	0	0	0	0	0	0	0	0	0	0	—	—	0	0	0

TABLE 3

HOSPITAL EPISODE STATISTICS (MATERNITY) 1990–91 ENGLAND

Estimated Percentages: METHOD OF ONSET OF LABOUR

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang*	*N.W. T.*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*	*SHA's*
All Methods	100	100	100	100	100	100	100	100	100	100	100	—	—	100	100	100
Spontaneous onset	75	72	72	78	76	77	73	74	79	74	73	—	—	74	77	76
Elective Caesarean	5	5	5	5	6	4	5	6	6	4	6	—	—	6	6	9
Surgically induced	4	9	3	2	4	4	4	3	3	2	5	—	—	3	3	2
Oxytocic drugs	8	8	11	7	11	3	11	10	6	14	5	—	—	9	8	10
Combination	6	6	7	7	4	4	6	7	5	3	6	—	—	7	7	3
Not Known	2	1	1	1	1	8	1	1	1	2	4	—	—	1	0	0

TABLE 4

HOSPITAL EPISODE STATISTICS (MATERNITY) 1990–91 ENGLAND

Estimated Percentages: PERSON CONDUCTING DELIVERY

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang*	*N.W. T.*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*	*SHA's*
All Deliveries	100	100	100	100	100	100	100	100	100	100	100	—	—	100	100	100
Hospital doctor	25	23	21	24	27	22	26	23	27	23	25	—	—	24	23	39
General practitioner	0	1	0	0	0	0	0	0	0	0	0	—	—	0	0	1
Midwife	72	76	70	64	72	75	72	76	70	74	73	—	—	74	73	60
Other	3	0	8	12	1	2	1	1	3	3	1	—	—	1	3	0
Not known	0	0	0	0	0	0	0	0	0	1	0	—	—	1	0	0

TABLE 5

HOSPITAL EPISODE STATISTICS (MATERNITY) 1990–91 ENGLAND

Estimated Percentages: DURATION OF POSTNATAL STAY (DAYS)

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang*	*N.W. T.*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*	*SHA's*
Mean	3	3	3	3	3	3	3	3	3	3	3	—	—	3	3	4
Median	3	3	3	3	3	2	2	3	3	3	3	—	—	3	3	4

Examination of Witness

PROFESSOR M J PECKHAM, Director of Research and Development, Department of Health, examined.

Chairman

112. Can I on behalf of the Committee welcome Professor Peckham, the Director of Research and Development at the Department of Health. We are very pleased to see you here before us, Professor. Can I put the first question to you? Could you describe to the Committee how you see your role and in what way it represents a departure from how research and development in the NHS were previously organised?

(*Professor Peckham*) Thank you very much. It is a substantial departure from what was before. I joined the Department on secondment in 1991 and my post arose from the report of the House of Lords Select Committee on Science and Technology, *Priorities and Medical Research*. This drew attention to the lack of emphasis on what they call the public health and operational research which includes Health Services research. It points to the fact that the Health Service was not in the mainstream of research, but rather separated from it, that the NHS did not have the capacity to identify and articulate its problems and present them to the research community, and, importantly, that there was no systematic use of research information, much of which languished unused, and that needed to be corrected. So that was the point of departure. My remit is to advise the Secretary of State across the range of her responsibilities and interests in research, but more specifically to develop a broadly-based R&D programme, many aspects of which are new. To summarise briefly it is convenient to think of the programme in terms of three components. One is the Department's own centrally-commissioned research programme, which was there when I came and which has been substantially reorganised over the last two years. The second aspect concerns alliances, fostering alliances with other funding bodies, with the Medical Research Council, particularly through the concordat, with more recently the Economic and Social Research Council, with the charities and with industry. The funding of health research is many-faceted in the UK and there has not really been the co-ordination between funding bodies. The third component, which is of course the new one, is the NHS Research and Development programme. Over the last two years we have been setting in place an R&D infrastructure in the NHS and developing an approach to the systematic identification and prioritisation of problems facing the Health Service as a basis for commissioning research, and an information strategy for research is being implemented. I am very happy to go into that in more detail. That is a new aspect and we think that it probably is the first attempt anywhere in the world to institute a coherent R&D infrastructure for health.

113. That is very helpful. Could you tell us what is the role of the Central Research and Development Committee and on what basis were its members chosen?

(*Professor Peckham*) Can I just put that in context? The Health Service programme has two components. Firstly, an executive arm through the Management Executive of which I am a member, and through the Regional Directors of Research and Development. Each region has a director of R&D. We have now appointed 13 of the 14 and there have been two new chairs established in Health Services Research, so that is how it is enacted, the executive arm, and I can elaborate on that. The advisory arm is through a new national research committee, the Central Research and Development Committee, set up in September 1991 and it is a non-representational committee. The CRDC is rather large because it attempts to put together the main interest groups of the Health Service. It includes academic medicine, NHS staff, general practice, nursing, economics, Health Services research. The chief executive of Glaxo has been a member and there is also a member of the public on it. It attempts to go from, if you like, molecular genetics to consumer interests and in fact the first meeting in 1991 was a very interesting experience because the 26 people approached issues from 26 different points of view. The exciting thing is that over a year and a half this group has come together and these cultural gulfs have largely been bridged. As to the remit of the CRDC, it is an advisory committee which is responsible for setting the broad strategic framework of the programme. What we are trying to achieve is a coherent national programme without undue duplication, but devolving responsibility to local level. I do not think this can be a programme which can be centrally directed and its prime purpose is to set broad strategy. I can elaborate for you how it is attempting to do that, if you wish.

114. That would be quite helpful to us, I think. I was also hoping you would tell us the role of the committee of the regional R&D directors. You mentioned it a moment ago, but can you explain how they also fit into this?

(*Professor Peckham*) The Central Research and Development Committee has adopted the approach of not setting up lots of standing committees; currently it has two. One is a group which is concerned with prioritisation, how do we actually identify priorities for research, what are the criteria for doing that. The second and more recent one is a new national Standing Committee on Health Technologies which is chaired by Professor Miles Irving from Manchester. This has six panels: pharmaceuticals, acute care, diagnostics, chronic care, screening and methodology. I could discuss health technology with you at some point because I think it is probably a critical development. The other approach has been to use short-term targeted expert groups that are convened around a particular problem. Our aim was to see whether we could work back from the burdens of disease and their cost to the NHS towards a research solution rather than the usual way which is science driven. In order to do this we decide to look at the NHS from six different perspectives. These are quite arbitrary and overlapping but one has to get into it in some way or another. We are looking at NHS issues from a disease perspective taking mental health, as the single biggest cost to the Health Service, as the first example. We have just completed cardiovascular disease and

[Chairman *Cont*]
strokes and are moving on to cancer. That is the disease orientation. The second orientation concerns problems in the management and organisation of the Service. The third relates to client groups, for example, child health, the elderly, the disabled, and what are the problems there and these are overlapping. The fourth approach is in relation to consumer issues, what are the key consumer issues. The fifth relates to health technology, as I have already mentioned in relation to the standing group. The final one is concerned with methodologies: what are the appropriate research methodologies to look at different models of management and models of care delivery and do we need to rethink that. The Central Research and Development Committee has convened these targeted groups which are backed up with information on prevalence, on costs and so on. This has already shown us huge deficiencies in what we know. Then the multi-disciplinary groups, rather like the Central Research Committee itself, have been asked to tell us what they consider the major problems are, not the surface issues but the problems, and to rank them in relation to their importance to the NHS. That has been quite an interesting exercise because we have had to invent a way of doing it because surprisingly it has not previously been done in any systematic way. As I say, we started with mental health and that was associated with a very large consultation exercise with different organisations, and not necessarily medical or even health ones. Then finally at the end of five months of the ranking exercise we are just about to place the first research contracts arising out of that exercise. To go back to your question about the Regional Directors of Research: we are identifying in each area of the programme a lead director. We started with mental health and the Director of Research in Yorkshire has been handed the money and is commissioning and managing the programme, on behalf of the Health Service even though the research is not based in Yorkshire, it could be happening in any other part of the country. He will be responsible and accountable for handling that programme and making sure that the research management and the delivery of the outcome occurs. We are now extending this approach. Professor Alberti in Newcastle is taking the lead on cardiovascular disease and stroke. We are attempting to develop a coherent strategy in this way with lead directors responsible for research management not with actually doing the research. The Group of the Directors of R&D is meeting very regularly at six weekly intervals because we are all on steep learning curves but there is already a very active programme emerging at local level.

115. Can you tell us how you disseminate the information on the agenda, deliberations and conclusions of these committees and sub-committees?

(*Professor Peckham*) That is very important. I think one of the major aspects, or one of the major defects, has been the lack of research information. If I could just illustrate that with an anecdote: if you take the database that we have in Oxford, on the effectiveness of care in pregnancy and childbirth which has been set up by Dr Chalmers and his colleagues at the National Perinatal and Epidemiology Unit, which many of you will be familiar with. This is a huge exercise which assembled all that we know on an international basis about effective care in pregnancy and child birth. The Oxford Unit has been supported for more than a decade. More than 40,000 obstetricians and gynaecologists were circulated worldwide to get this information. Having assembled this at a cost that can only be speculated about, we do not know whether the information is being used or not. In fact, we do know that, for example, antenatal steroids in women with threatened pre-term delivery can be highly effective in preventing respiratory distress syndrome in babies. We also know that in some districts as few as 10 per cent of such women receive steroids, which is a very cheap treatment. This is an example of the lack of the use of research information and it must be corrected. A second enormously impressive anecdote to me concerns the trials that have been done to examine thrombolytic therapy (clot dissolving therapy) after heart attacks. Seventy trials have been done on a worldwide basis but if you track back these trials and do a systematic overview you can demonstrate that by 1972 the 10 trials already published provided enough information to say that this was something that would work and was effective but because that was not disseminated 60 more trials were carried out. There was a 12-year delay before thrombolytic therapy began to be recommended in intensive care. The whole subject of the use of research information is much neglected and very interesting. We have developed an information system strategy which has four components. The first is a research project database and that is to allow us to know what is going on, who is doing what and where. Last year Dr Robin Dowie, who is working with me, constructed a "snapshot" of research going on in the Health Service. She identified more than 6,000 projects nationally, much of which was for "invisible" research, not known about. We need to know what is going on before we actually place contracts for research. That is being set up. Secondly, we opened in November 1992 the Cochrane Centre in Oxford which is being directed by Dr Iain Chalmers who has had the incomparable experience of setting up the National Epidemiological Perinatal Unit database I mentioned before. The aim of the Cochrane Centre is to construct a database of trials but also to facilitate the systematic overview of clinical trials which still remains one of the powerful ways of measuring the effectiveness of treatment. The unit is not primarily concerned with carrying out analyses but with being the final common pathway establishing links with other national units and, more importantly, internationally. It is a first step at really tapping into the international effort. What has been very exciting is that the Canadians have decided to fund a Canadian Cochrane Centre and the Swedes are also putting money into it. It is beginning to become a network. The two other components, just very quickly, are a facility for commissioning reviews of existing research data which complements the Cochrane Centre and then finally a facility which is going to be concerned with dissemination and systematic transfer of research information to researchers, to clinicians, to managers and so on. That will be an entirely new endeavour which will

[Chairman *Cont*]
require new skills. That is our information system strategy.

116. Will the conclusions of the CRDC actually be published and will they be available?
(*Professor Peckham*) Yes, we have a policy of transparency of operations and the CRDC papers are actually made available to anybody who wants to see them. All research findings will be freely published, that has been agreed, and in 1991 we produced a document called *Research for Health* which was more or less setting out what we wanted to do. On 29 June this year we will be launching a document which brings everything up to date and tries to describe what we have done and where we think we are going.

Mr Clappison

117. I was absolutely fascinated by what you were saying about the comprehensive overview form of research. I wonder if I could ask perhaps a naive point which is did you find when you were forming that that there were many examples of duplication in the 6,000 or so projects you mentioned and what safeguards are there against duplication?
(*Professor Peckham*) Well, some duplication is all right and more than one group actually doing something is quite healthy. But excessive duplication, particularly where people are not aware that someone else is doing it, is not. Actually what came out of the study was that when research was funded by a peer review body, like the MRC or a major charity, there tended not to be too much duplication and if people actually looked at what is happening in diabetes research, then the situation is pretty good. If you take research which was funded by a health authority on whether, for example, GP mini-clinics for diabetes was the way to go, then you tended to find the same kind of research projects being repeated without researchers being aware of it. I think that this is relatively easily correctable by simply demonstrating to people that there is an exact duplication and why do this when two other groups are doing it.

Tessa Jowell

118. The question of how you actually get research to influence clinical practice is a fraught question. The Department of Health has for years had shelves full of reports, all with wordy conclusions which have had absolutely no impact on clinical practice out in the field, and I was very interested in what you were saying about how you actually see the findings being made accessible to people who are engaged in practice. But I wonder if you could actually say a little bit more about it because dissemination in a sense is a critical second stage for research, is it not, which probably comes before development, before the rather more general impact on services?
(*Professor Peckham*) Yes.

119. What I would like to hear is a bit more about with whom or where you think the responsibility for dissemination lies. Is it your job or is it a function which lies elsewhere in the Department? The risk obviously is that it is a function which gets lost or which is happened on by chance.

(*Professor Peckham*) Well, that is an absolutely critical question. There is the output of research, there is the uptake of it and then there is the impact it makes on practice. We are, I believe, constructing a pretty coherent approach which involves the Health Care Directorate in the Department of Health working closely with the Research and Development Division. Our job is to actually provide, I believe, the knowledge base for the Health Service—valid information which is relevant, timely, and which actually is made available in the appropriate format. This of course means that we have to discover how to do that, but that is our job, to find the basis for good decision-making. I believe that the research is involved at various points right through to implementation, but what we are working towards is a link with the Health Care Directorate which will involve clinical guidelines, the uptake of guidelines, the use of audit to probe the usage guidelines and outcome measurements and so on, so that there is a fairly seamless approach to this. I think in the past the reason why research has not been used is quite complex. On the one hand I think that the researchers have not been very interested in seeing their results used and surprisingly have gone back and done more research. Research results may not have been made known to people so they have not used them. But of course there are other reasons. For example, if you take the introduction of minimal access surgery, an absolute revolution in surgery, there is the question of abandoning old skills and learning new skills and this is quite threatening. So there are various obstacles to the use of data. One of the things that we are doing at the moment is working with purchasers to identify the information requirements for actually making the contracting process more susceptible to the use of research information. There is a whole theme of work which is going on with the purchasers because this represents another potentially powerful lever for getting research information used. A good example of that is the use of antenatal steroids, which I mentioned, is now being incorporated into certain contracts. I hope that answers your question.

120. But do you feel that dissemination is a function that needs to be strengthened within the Department?
(*Professor Peckham*) I think yes. Well, I think it is being strengthened by what—

121. Clearly from what you said, but I mean further strengthened.
(*Professor Peckham*) Yes, I see that we have two roles. One is to create the knowledge base, and the other is to produce a research receptive and evaluative culture within the NHS. This would be quite different from what the situation has been, so that is another contribution towards this. But I do not think we need to do anything further by way of dissemination other than the four components of our information strategy at the moment.

Mr Clappison

122. What will be the roles of the regions in doing work in identified priority areas?
(*Professor Peckham*) The Central Research Committee is tackling a limited number of high-priority areas in relation to burden of disease. This

[Mr Clappison *Cont*]
leaves a huge area of health untouched and this will certainly be the remit of the regions. For example, we do not yet have diabetes as part of the central programme simply because we are already tackling a fairly broad range of issues. Diabetes will be tackled by one of the regional directors with particular expertise in that area, but using the methodology that we have established and also not necessarily relying simply on regional expertise. I think the regions will be using the same sorts of experienced groups as the CRDC which are drawn nationally and in a multidisciplinary way.

123. Do you feel regional directors will have sufficient powers to advance this work in priority areas?

(*Professor Peckham*) I do. There has been a very interesting discussion about the sort of people who ought to have been appointed as regional directors. It so happens that most are rather senior medical academics. One way of looking at this is, "Oh well, the whole programme will be hijacked by medicine and there will be a re-run of the biomedical model of research". But unless we get on our side the real leaders in research, the people with track records in research, and bring their experience to bear on this neglected area of health services of applied research, then it will not run and it will always be a peripheral feature. So I am pleased it is going well and I believe that the directors will have the clout to make this happen.

124. Do you feel able at this stage to say anything about the relationship between priorities seen at the centre, such as the *Health of the Nation* targets, and priorities on the ground in the regions?

(*Professor Peckham*) I think it is all part of the same thing. Let me give you an example. When we reviewed mental health we identified, or the expert group identified, some 30 problem areas. We took the top seven and invited bids from the research community and we passed seven areas to the Medical Research Council as part of the concordat they have and they have taken some of them to fund. I can also say some of these were very applied areas of research, for example, the quality of residential care for the elderly and mentally ill, and it resulted in the development of information packs for non-medical people working with the mentally ill under community care. I wondered whether there would be interest from the research community. In fact, I was pleasantly surprised because we had almost 500 submissions from the research community for these areas of work. The other areas were passed to the regions and they are now incorporating them into their regional plans. Each region is required to produce an annual plan. They produced the first one in September last year and it will be updated on an annual basis. The *Health of the Nation*, both the target areas and where targets would be set if we had more information, are fed into this process, both in setting priorities regionally and in the Central Research and Development Committee.

Mr Sims

125. It would be fair to summarise what you have been telling us, Professor, and say that you and your committees are, in effect, saying: "Well, what research is going on now and to what extent does it need to be co-ordinated and duplication avoided and what research needs to be done" and you then proceed to commission that research? Is that a fair summary of your position?

(*Professor Peckham*) The really new thing, I think, about this programme is that it is working from the problem towards the research solution rather than the reverse. The health systems of all countries have been shaped by science. That will remain a very potent force because we are actually in the middle of an explosive development in new medical technologies. Working from the problem backwards is the new thing about this programme. What we would ideally like to do is to identify a problem, let us say the quality of residential care of the elderly mentally ill, and then say can we be sure that we do not already have the information relevant to this? Therefore, we need to know what we know. We need to be able to commission rapid revision of existing research. The second question is, if we do not think we know the answer then is anyone doing the research already? If the answer to that is no then we should commission research to answer the question. That is the grand strategy, to get to that point. It is, in a sense, targeting research to high priority areas but making sure you need to do it.

126. Thank you, that is very clear. You said a few moments ago that you identified 30 such areas?

(*Professor Peckham*) Yes.

127. And you have prioritised seven of them, is that right?

(*Professor Peckham*) We selected the seven high priority areas in mental health. We invited bids by placing advertisements in the national press and in the medical press from the research community. We, of course, received many proposals for tackling those particular issues so we placed contracts for more than seven projects.

128. Could you tell us what those seven areas are? I imagine mental health is one?

(*Professor Peckham*) Examples are behaviour therapy for psychosis, community based respite care for serious mental illness, training packages for depression in primary care, training of community nurses and needs assessment of dementia. In cardiovascular disease and strokes, where we have just completed a similar exercise, the sorts of areas being identified are rehabilitation after stroke, cardiovascular disease studies in women (because most of the studies have been in men), secondary prevention of angina or after a previous ischaemic attack. What is coming out of these problem-setting exercises is a mixture of problems which have a community orientation, a primary care orientation, and a more biomedical feel about them so it is an interesting mix.

129. Just on the mental health one: are you satisfied that there are effective and proven methods of evaluating the intervention in mental health treatment as distinct from the treatment itself?

(*Professor Peckham*) Evaluating it?

130. Yes.

(*Professor Peckham*) I think that we are not satisfied that we have methods for evaluating much

[**Mr Sims** *Cont*]
of what we want to do. This is why we have a perspective which deals with methodology. In mental health there are some very good studies of, for example, the use of randomised control trials to look at psychiatric nurses in relation to the medical management of selected conditions. The mental health field has been quite good at using these methodologies. Overall we certainly need to think about research methods. This is illustrated very clearly, not in the mental health field, by endoscopic minimally invasive surgery which is moving so quickly that to try and apply the randomised control trials as a method of evaluation would be very difficult. We cannot simply say: "Stop for five years so we can evaluate you". We have to find ways of evaluating fast moving technologies. The other aspect, of course, is that the more qualitative approaches of the social sciences need to be looked at. At the meeting we have of the Central Research and Development Committee next week, one of the agenda items is the contribution of social science methodologies to the whole programme.

131. I was not surprised to hear you mention cardiovascular disease, that is very common, but it is a field in which a lot of research is being done and financed by the pharmaceutical companies. Do I gather from what you are saying that you are looking at those areas that presumably pharmaceutical companies are not?

(*Professor Peckham*) Yes, we are. We are tackling areas that have really been areas either of little emphasis or neglect. I mentioned at the beginning the notion of developing alliances with other bodies. The first one we set up was a Cardiovascular Research Liaison Committee, chaired by Sir Raymond Hoffenberg. This brings together the British Heart Foundation, the Medical Research Council, the Stroke Association, the Wellcome Trust, the Department of Health and industry. The attempt was to get the main players in the field of funding research in cardiovascular disease around the table to understand their strategies and planning, their priorities and to look for opportunities for joint funding and for collaboration. Everyone likes their autonomy but I believe we are seeing this initiative beginning to take off. We have done this now in respiratory disease and—

132. Does the problem of commercial confidentiality come into it when you have industry representatives?

(*Professor Peckham*) We debated this and on all the committees we have industrial representation and I feel this is very important. They are there not actually as representatives of their firms but to bring an industrial perspective, an industrial R&D perspective particularly, to the discussion. Input into research liaison committees is precisely along those lines rather than it being from a particular firm.

133. Could I ask if accident and emergency come into the picture at all?

(*Professor Peckham*) Accident and emergency have not yet been tackled but there are many areas which have not yet come into this programme. It is pencilled in, but not yet.

Rev Smyth

134. Professor, you have heard the examination of the statisticians from the NHS and the Department. You are possibly also aware that quite often Members of Parliament get answers to questions that we have not got the information centrally and it would be too costly to collect. I find that difficult, especially in Northern Ireland where you have that much smaller area, to get that sort of an answer. I am asking you, do you have enough high quality information to know what is going wrong or going right in the NHS and therefore to help you determine the priorities for operation and success?

(*Professor Peckham*) I would say that there is a lack of information and this is well recognised. Probably it would be best corrected by actually identifying when you really need it. Just to give you an example: when we set out to identify the priorities in cardiovascular disease we produced background papers on the prevalence of different conditions and on economics. You then begin to find quite serious deficiencies. We do not know, for example, how much chronic recurrent depression costs the NHS or at least we do not know that in detail. So the answer to your question is yes, there are deficiencies, and this programme is highlighting them. I think that is actually healthy because this is the first step to correct it.

135. That is a helpful answer and it shows a negative, as it were, how you got out some of that information. What lessons would you say you have actually learned from the information gathered from the NHS on the ground? Is there any illustration that would help us understand part of the work that you have in your research and development?

(*Professor Peckham*) Yes, I think that one example is information on what I would call anomalies, anomalies in the way the service works which is true, I suspect, of other Health Services. For example, if you look at the use of procedures, the use of dilatation or curettage or hysterectomy you find very substantial differences, three or four-fold differences between different districts. If you look at referral rates for coronary bypass grafts, similarly you find differences. If you look at the percentage of patients who are tertiary referrals and whether they are near the specialist centre or not near the specialist centre, many more patients from the locality of the specialist centre are referred from GPs rather than consultants. I believe this begins to highlight some very important information. Just to take another anecdote, if you take waiting lists, there is some very interesting information. Perhaps the best example, or the one I always use which interests me, is the study on a varicose vein surgery waiting list. Professor Fardon from Bristol looked at the waiting list by inviting all the patients for examination. The upshot was that of 300 people on the waiting list, less than 30 per cent of them ended up having in-patient surgery. So in relation to the effectiveness of treatments these observations, I think, have been able to begin to point us in the direction of research, so I think they are quite valuable in that context.

136. On the level of waiting lists, have you been able to discover any pattern that gives some clue as to the real waiting lists, in other words, the large

[Rev Smyth *Cont*]
number of people throughout the country who do not as yet appear on waiting lists because there has been a rationing out, simply on the gatekeeper's level?

(*Professor Peckham*) I think there is quite a substantial body of work in hand which might shed light on this, for example, work on health needs assessment of population and waiting list research itself, but I think the answer is we do not know yet.

137. And the GPs, for example, do not keep records because they are not referring them because they know it will be months before they can be seen by consultants. What input, because you touched on it, do you have on the design of the data sets for collection from the National Health Service?

(*Professor Peckham*) I would say we have not had input into the design of data sets, but I think I would say that there are an awful lot of gaps at the moment because you will appreciate this has been a pretty busy two years. A lot has been happening and still there are obviously things we could do, but the answer is we have not been into that particular aspect.

138. Would you like to be able to go into that?

(*Professor Peckham*) I think it makes a great deal of sense for R&D to underpin a wide range of activities. It should not be seen as an additional activity, but as an underpinning activity, so in terms of an information system and data-gathering I think the R&D input is absolutely invaluable.

Audrey Wise

139. You have mentioned that you are doing work to find out what research is actually being conducted. You have told us about the national register of research and the work of Iain Chalmers in this. Can you tell us whether the records of applications to local research ethics committees will form the basis for this record of research in progress? Will it have any place in that?

(*Professor Peckham*) This is something that we have discussed and the way in which our research database will work is that each regional director is now charged with developing a register of research on his particular patch. I have no doubt that research ethics committees will be one way into that. Initially, because this is potentially such a sizeable undertaking, it will be restricted to NHS and Department of Health supported research, but with a view to interfacing the database with the Medical Research Council and with the Association of Medical Research Charities. We will then begin to get a complete picture of research.

140. Ethical questions are obviously very important in lots of areas of research. Do you think that the information that you are gathering on what research has been conducted will also be useful in tracking to make sure that ethical questions are being addressed and that ethics committees know what research is being conducted, for instance?

(*Professor Peckham*) I think that is an interesting point because if research is being unnecessarily repeated, you could argue there is an ethical issue there because it does not need to be done and people are being subjected unnecessarily to research. I think of equal importance is that there are other issues that have not always been addressed by ethics committees. One concerns the importance of the question that is being posed and the second is the scientific standard of the study design. Generally speaking people have said to me that a substantial proportion of projects going through some ethics committees are unlikely to deliver a definitive answer to the question they are setting out to address. If that is the case it seems to me to raise rather an important issue. But I think there is a very important connection between research and ethics.

141. The National Perinatal Epidemiology Unit in gathering together the information which it did, also developed indicators as to what further research was needed and on priorities. Do you envisage that the national register at the Cochrane Centre will have a similar significance and do you expect the information which it gathers to be of use in indicating priority areas?

(*Professor Peckham*) The activities of the Cochrane Centre, by identifying real gaps and deficiencies, will point us in the right direction. If you take the attempts that have been made to review studies of cost-effectiveness, first I think was the Michael Drummond study, but more recently Clive Smee in the Department of Health has put together all the data that we can identify on cost-effectiveness. It is actually quite a small amount of work and what you find is there is a skewed effort, so there is quite a lot of work on cardiovascular disease and cancer, but very little in mental health. So I think this kind of exercise will demonstrate gaps which is one of the reasons why we started with mental health.

142. How will people actually get a hand on determining priorities? You have given a very clear account of the committee structures and you have made it very clear, this interesting concept about it being problem-driven, which I think is a very good development. But thinking of it from the point of view of the user, and I noticed that you mentioned a user on the initial committee you described. For instance, in the maternity field, what the NPEU discovered and what was picked up by this Committee is that there is a dreadful gap in relation to research on post-natal problems and I mean both immediate post-natal problems and after, say, the first three years. How will your structures help you to identify problems like that which may not be very much in the consciousness of professionals but they are certainly in the consciousness of women in that particular case?

(*Professor Peckham*) We actually attach quite a lot of importance to this and we do not underestimate the difficulties. One of the six perspectives by which, as I mentioned, we are approaching the NHS to identify priorities, concerns the consumer. We have initiated this by commissioning a paper from Mildred Blaxter and that has now been taken forward so we have a whole theme which is looking at consumer matters and how we address the very problem which you raise.

143. Do evaluations so far suggest to you that research is skewed often to comparative drug trials rather than, for instance, the effectiveness of drugs versus not drugs?

(*Professor Peckham*) Yes.

[**Audrey Wise** *Cont*]

144. If that is so, do you have any proposals for doing anything about that?

(*Professor Peckham*) Yes, we have. The answer is that yes, it is true, there is a skew of emphasis. I mentioned the health technology standing group which is composed of the chairmen of the six panels and if I just briefly mention them: there are panels on pharmaceuticals chaired by Michael Rawlins, the Chairman of the Committee on Safety of Medicines; on chronic care including community and primary care; on acute medical and surgical care; on screening; on diagnosis, including imaging; and then another one on technology assessment methodology. The last one is chaired by Professor Culyer and the others are chaired by experts with particular experience in the field. The overall standing group is composed of the six chairmen but there are other members to provide a multi-disciplinary spread. I see that as a very important development because first of all when we talk about technologies, and we use that awful term to describe health practice methods, it includes surgical procedures, medical care, staff-mix issues and so on. We want this group to give us some kind of map when we are talking about technologies. Secondly, to provide the criteria for prioritising the assessment process. Assessment itself is quite expensive and we really need to target our resources to try and assess technologies of high priority. The third thing I want the group to do is to advise us on new technologies that are coming along which will impact on the service. That is a very real issue. New technologies are coming not just from medical research but from the defence industry and the nuclear industry and from a wide range of sectors impinging on health. The technology standing group will address the issue which you mentioned. It will not just be looking at drugs but at the whole range of issues and advising us on the assessment process.

145. The coming of the market into the NHS has brought some new factors into the picture.

(*Professor Peckham*) Yes.

146. Notably the question of confidentiality and one trust establishment seeking to keep its own place in the market perhaps against another. I was very pleased to hear what you said about transparency and openness. What will you do if you come up against problems in relation to commercial confidentiality which exist even within the NHS?

(*Professor Peckham*) There are two aspects to that. I did mention we have openness and we are very aware of this. We do not want local research activities to be used purely for local advantage. I think that is quite wrong, it is not in the spirit of research which should be freely available. What is encouraging for me is that the regional directors have in many cases already identified contacts with people in trusts as well as in the health authorities so there is a real network emerging. The issue of confidentiality is something that is not of current concern. We will keep an eye on it obviously. The second aspect which is related, is perhaps not what you meant to raise but it concerns the exploitation of NHS innovation. We may wish to commercially exploit some of the innovations which arise from this programme and we have made a start in that direction. We have commissioned a paper on intellectual property rights.

Mr Congdon

147. Can I turn to the question of funding. I understand your target for funding is 1.5 per cent of the budget. On what basis was that figure arrived at? What is the current percentage? What does that represent in cash terms in the current year?

(*Professor Peckham*) When we presented our proposal to the NHS Policy Board in 1991 we felt that if we thought R&D was important, there should be a percentage commitment to it. I believe it is important to the NHS. The figure of 1.5 per cent has a certain arbitrary quality to it although it is within the range of the funds committed to R&D by service industries, which is usually between one and two per cent. We estimated then that something like 0.9 per cent was already in the system and that amounts to about £300 million. It does include quite a lot of fixtures like the service support for research. I can go through that if you like but at the moment we estimate the expenditure to be about £300 million. We are moving from about one per cent to 1.5 per cent. We do not know with any accuracy how much money is being spent by the NHS on research. We made the first estimate in 1992 and at that time we estimated the regions were spending about £40 million. We have set up an R&D finance information group which brings together finance directors and regional directors of research to try and work this out. One of the promises, if you like, for moving towards the target of 1.5 per cent was that we would clearly identify the existing expenditure and make sure that existing funds were managed properly. I can send you more details of funding.[9]

Chairman: That would be helpful.

148. There is one further point. You are saying you have not got an accurate figure of what is actually being spent, you are trying to get there, but how much of the one and a half per cent or whatever the percentage actually is will be accounted for by the relabelling of money for other things such as Service Increment for Teaching and Research monies or will the extra be new money?

(*Professor Peckham*) In the money I mentioned to you, the £300 million, that includes the research component of the Service Increment for Teaching and Research, assuming that is 25 per cent, and also includes a tranche of money presently allocated to the Special Health Authorities in London.

Chairman

149. Can you tell us what proportion of the total regionally allocated research budget will be top-sliced for national research projects, and what does this represent in cash terms?

(*Professor Peckham*) Yes. In 1993/94, the top-sliced budget for the national NHS budget is £12.6 million. That includes the non-SIFTR scheme for district hospitals (£2 million), £4½ million for the Central Research Committee and £1 million for the information systems strategy.

[9]See Supplementary Memorandum, p. 43.

Tessa Jowell

150. Why was the research project into co-operative working between doctors and nurses, which you announced on 21 January, given to a management consultancy rather than one of the very qualified non-commercial Health Service research units? It was a decision which at the time caused, I think, some surprise.

(*Professor Peckham*) I have to say I was not intimately involved in this decision, but I will try to answer, nevertheless. It was actually put out to tender and there was competition. It was not simply that one research group was picked upon. I think that four tenders were invited. I have read this proposal and I think it is a very good proposal. I think it is quite soundly based and it is looking at doctors' and nurses' roles in acute surgery, medicine and paediatrics and the acute care of the elderly in each of two sites in each of the three regions. There is extensive consultation and literature associated with it, so why it was not made more widely available, I cannot answer.

151. And of the four submissions you received, were any of those from Health Service research units?

(*Professor Peckham*) I would have to check that.

152. You would perhaps let us know.

(*Professor Peckham*) I will let you know that certainly.[10]

153. Will the research be published?

(*Professor Peckham*) Yes.

Mr Clappison

154. Can you tell us the basis on which the concordat has been agreed between the Department and the NHSME and the Medical Research Council?

(*Professor Peckham*) Yes, the new concordat was negotiated in 1991 and has operated since January 1992. It has led to quite a substantially different mode of interaction between the Health Departments—not just the Department of Health of course, but the territorial Health Departments—and the MRC. The MRC have created a new board in public health and Health Service research and they have created a new strategy committee known in the jargon as "needs pull" where health priorities can be presented. We make known the outcome of our prioritisation exercises to the MRC and we on our side have set up an MRC sub-committee of the Departmental Research Committee which looks at relevant MRC grants. Obviously this does not include all the basic science grants, but those which are relevant to the Department. Ratings are assigned in relation to the priorities that the Department places on them, so it provides the basis for the MRC responding to the priorities of Health Departments, but it is more than that. It also obliges us to really relate to the whole of the MRC portfolio, including the basic science one because one of the things I probably have not got time to mention is that in addition to addressing the gap in Health Services research, we need to interface the Health Service with basic science to take advantage of science opportunities. So, for example, we have set up a group looking at basic genetics, including genome-mapping and how that will impact on the Health Service. We have had the first annual stock-taking of the new arrangements with the MRC and although it is still the honeymoon period, I think everyone thinks it is working extremely well.

155. Do you have any comments to make on the implications of this on the reallocation of funding?

(*Professor Peckham*) The reallocation of funding?

156. Well, the allocation of funding between the different bodies.

(*Professor Peckham*) Could you just elaborate on that?

157. What are the implications of the concordat for the funding of this?

(*Professor Peckham*) There are no direct funding implications. There is a long history in the concordat of money being handed back to the MRC. I felt that it would be totally inappropriate to do anything about trying to reverse this so that was ruled out. This is in the spirit of the MRC responding to priorities without us saying how much of their budget should be spent on those priorities; it is unspoken.

158. Do any problems arise from the MRC being answerable to a different minister?

(*Professor Peckham*) No, I do not think that is the case. In fact I can say that the Office of Science and Technology and the Chancellor do, I think, see the arrangements between the Department of Health and the MRC as a good model of how government departments and research councils can interact. In fact we have now, as I mentioned, extended this to a less formal 'concordat' with ESRC.

Audrey Wise

159. You commissioned a review of research units in 1991 as a result of which there was a recommendation for large units. In December Dr Mawhinney said that there is something in this proposal and he said, "We shall set up such a centre as a pilot project". Can you tell us on what kind of contract that proposed major research centre will be? Will it be on a rolling contract or fixed-term?

(*Professor Peckham*) The plans are to create a first pilot R&D centre, with the objective of giving this whole area of research prominence and creating critical mass for a real multi-disciplinary group. The plan is to commit up to £1.5 million a year, so it is substantial funding, to create a real core and to provide that funding for ten years. But there will be rather strict and practical arrangements associated with that.

160. Thinking of the people working in the centre, will there be a distinction drawn between people regarded as core researchers and some people brought in on short-term contracts? Will it work like that?

(*Professor Peckham*) One of the aims also is to embed the centre well and truly in a university, but we would certainly see the core staff as being very much related to the interests of the Department. I think that it would not preclude the centre, and indeed we would encourage the centre to be seeking funds from other sources. So we would imagine around the core staff will be other staff supported from other sources.

[10]See Supplementary Memorandum, p. 43.

[**Audrey Wise** *Cont*]

161. Dr Mawhinney also said, "Some smaller units will remain and current units producing excellent high priority research will be granted fixed-term programme contracts in place of their existing rolling contract". Has it yet been decided which smaller units fulfil these requirements?

(*Professor Peckham*) No, we are engaged in a review of all 13 research units which will be completed in the spring of next year and these are all on-site visits of their current work.[11]

162. That would include the NPEU, for example?

(*Professor Peckham*) In June of this year, yes.

163. This Committee recommended very strongly that the NPEU should have a secure future existence.

(*Professor Peckham*) I am aware of it.

164. The body of experienced health research workers is very small, relatively speaking. What are you doing to reinforce their morale and make them feel that their work is really useful and appreciated?

(*Professor Peckham*) I have met with all the Department of Health researchers and heads of units and I have visited all the units. I think they are now persuaded that the move towards larger centres is a way of strengthening career structures for Health Services research and obviously I am very committed to doing this. In fact several weeks ago we ran a one-day workshop on research training and career structure. At the two-day away meeting of the Central Research and Development Committee next week a major item will be career structure and training.

165. Do you think it is appropriate to keep full-time research workers on continual short-term contracts? Why should they not enjoy the same kind of terms and conditions as, say, NHS consultants?

(*Professor Peckham*) My view would be that I do not necessarily see that the Department has a commitment to provide a long-term career structure; universities have that commitment. We should fund positions in universities. That will be the spirit of the commitment to fund for ten years. Many universities are keen to get this and to underwrite it thereafter. That is the way we should go.

166. Surely the Department should have an interest in ensuring the continual supply of good quality research staff? Is not a question of security and proper conditions part of doing that?

(*Professor Peckham*) Absolutely, but one of the reasons for having alliances with other interested groups, with universities, with charities and research councils, is to persuade them to take on some of those responsibilities.

Mr Sims

167. Doctors applying for consultant posts in the NHS are encouraged to display a long list of publications covering a wide range of topics. How do you intend to get them to apply themselves to your priority areas of research and to achieve the targeted depth rather than a random spread of research?

(*Professor Peckham*) Very briefly, I think the provision of research training and the experience of doctors needs to be radically rethought; that is my own view. This was debated publicly a few weeks ago in the one day workshop. I think a well structured biomedical research experience is excellent, so long as it is well-funded, well-supervised and so on. But often it is not like that and research experience is poor. I think it would be better for many doctors to have experience in evaluative science, in statistics, in epidemiology, economics and Health Services research which they can then use on an ongoing basis. We are pushing that idea, we feel that is rather important.

168. So the proposition that they should be limited to half a dozen papers which should have direct relevance to their NHS work is one which—

(*Professor Peckham*) Which in the fullness of time might happen. The creation of research fellowships has been identified by regional directors as a priority. There are research fellowships not just for doctors but for nurses and other health professionals springing up.

169. Obviously a certain amount of research goes on within SHAs and postgraduate institutes but what proportion of that is of direct relevance to clinical priorities in the NHS? How does that fit in with your research?

(*Professor Peckham*) We are engaged in a review of the eight R&D postgraduate London hospitals. This is an extensive exercise. The review committee, chaired by Sir Michael Thompson, is reviewing each of the eight hospitals. It is an interesting review because it is the first time there will have been a review of NHS academic hospitals as opposed to the university components or institutes. We are looking at their R&D mechanism for taking R through to D and exporting D to the NHS. That will be completed by June.

Audrey Wise

170. We have had some discussion on dissemination but returning briefly to that point: how do you plan to make clinicians aware of what is going on? Do you think it is lack of awareness or other things which are the most important? This Committee is very conscious of this problem. When we did our maternity inquiry we looked at the research matters in relation to maternity services and we discovered there was research published in 1989 which showed the suture material for repairing episiotomies was a form called soft gut which was dearer and caused trauma for the women and pain up to three years after the birth, yet it was still in quite common use. The reference to this in our report led to a change in clinical practice to such an extent that we got a complaint from the company that manufactured it because we were endangering their livelihood. It seems very strange such a thing can happen and it does come back to the root of some of the problems. Are you confident you are going to be able to tackle this?

(*Professor Peckham*) I think things are changing. I am an optimist and I believe there is beginning to be a climate change already. The R&D programme has begun to permeate, to percolate, and there is an awareness things cannot go on as they were before. That is a non-specific answer but rather important. I think through the route I have already outlined of

[11] See Supplementary Memorandum, p. 43-45.

[**Audrey Wise** *Cont*]
incorporating this information into the purchaser/provider contracting and the use of an audit based on clinical guidelines, that this is a very promising way to go. These things are in hand and being dealt with.

171. Will this good work extend to the Department itself? I can give you a simpler example than yours of a lack of use of research findings and that is the work of the Department itself which resolutely ignored the findings of the NPEU that universal hospital birth is something that should be abandoned. If the Department refuses to recognise the work done by its own units it is a bit difficult to expect anyone else to. Will you be able to get your fangs into that?

(*Professor Peckham*) I am going to answer that somewhat evasively. I am very conscious of the point you are making and I think research findings should be used to refine and shape policy as well as facilitate policy. We have, to give you a specific example, launched a review of the personal social services research where the Department is the main funding body and which is chaired by Professor Gilbert Smith from Hull. This will report in November. We are looking at the connection between the research which has been commissioned and policy. I think it is a very important area and I am keen to see it addressed.

172. There may be vested interests involved but you talk of the need to learn new methods. What sort of clout do you think you will have in medical training for example? You have referred to the need for some changes in this but will the work you are doing have an impact, do you think, on that kind of field?

(*Professor Peckham*) I have to say I think this will be an evolutionary process frankly. This will be through liaison with undergraduate deans and postgraduate deans. That is already beginning to happen. Linkages between the regional directors of research and postgraduate deans, that connection is being made. It will happen but it will take time to happen.

173. Are you conscious of any need to address the sex balance, for example, in the personnel of your committee and the people deciding on priorities? Women are heavy users of the Health Service and often feel their needs are not really taken as a priority.

(*Professor Peckham*) The sole criterion is quality—but it so happens it balances out quite well.

Mr Congdon

174. Are you proposing to address the concerns among researchers taking contracts with the NHS about Crown Copyright? Are you prepared to support their right to publish their findings?

(*Professor Peckham*) The researchers funded through the NHS programme are free to publish their findings. That has been agreed.

Mr Bayley

175. To follow that up, if, for instance, an individual health authority commissioned a piece of research, would the researchers be free to publish their findings and if the Department of Health commissioned in-house a piece of research on infant mortality, would the clinicians or the economists or whoever had done it be free to publish without the blessing of the health authority?

(*Professor Peckham*) That is an interesting question and really my response relates to work funded through the NHS programme. I would assume that could be extended to the health authority, but I would have to check that.

176. In your case the answer would be yes?

(*Professor Peckham*) Yes.

177. You would talk to the person providing the research and in most cases if there was a dispute you would find out what the problem was?

(*Professor Peckham*) One of the points agreed, and it was made public, was that there would be freedom to publish within the NHS programme and I would assume that included health authority supported work.

Chairman

178. What thinking is being done about research into what forms of care, both in health and in social services, the taxpayer should be funding?

(*Professor Peckham*) That is a difficult one. Do you mean what the taxpayer might not fund?

179. You could put it like that, yes.

(*Professor Peckham*) I think that in terms of priorities in care, whatever euphemism one wants to use, but priorities in care is the one I would use, what this programme can do is to provide a basis of information on which policy decisions will have to be made. But I do not think that we in the research and development industry are in a position to make those policy decisions.

180. In New Zealand, which we visited very recently, they have a core advisory committee which is looking at this. I wondered what your reaction was.

(*Professor Peckham*) Yes, I see.

Chairman: Can I thank you very much, Professor Peckham, for giving such very full answers to our questions. We have found it extremely helpful and we have found out much more about your role at the Department of Health, you and your colleagues. Thank you very much indeed on behalf of all the Members of the Committee for coming before us this afternoon. We are extremely grateful for your time.

Memorandum Submitted by the Department of Health following evidence from the Director of Research and Development on 21 April 1993

(Q numbers relate to Question numbers in the oral evidence)

QQ 147–8: *NHS R&D Funding*

1. The decision to increase NHS R&D expenditure to 1.5 per cent was based partly on an estimate of what would be required to meet the recommendations of the House of Lords Science and Technology Committee report on "Priorities in Medical Research" (1988) and partly on a desire to underline the Government's commitment to the NHS R&D Strategy by signalling a "step-change" in funding NHS R&D.

2. Our present best estimate of NHS R&D expenditure is approximately 1 per cent of total gross NHS expenditure in 1992–93. It is not possible to give an accurate figure as some components of NHS R&D expenditure require more detailed measurement systems to be developed.

3. The spend on NHS R&D in cash terms is estimated at £316 million for 1992–93, broken down as follows:

London Postgraduate SHAs[1]	£100M
The research element of SIFTR[2]	£ 95M
Department of Health NHS[3]	£121M
Total	£316M

[1]Research expenditure within SHAs is taken to be one-third of total central funding of £300 million.

[2]Taken to be one-quarter of total SIFTR expenditure of £380 million.

[3]This includes £26.9 million of R&D from health-related Non-Departmental Public Bodies including Public Health Laboratory Service. National Radiological Protection Board. National Biological Standards Board, Health Education Authority and Central Blood Laboratories Authority (now National Blood Authority).

Q 151–2 Project on Cooperative Working Between Doctors and Nurses

1. The aim of this research project was to contribute to an improvement in patient care by examining the interface between junior hospital doctors and ward nurses with a view to enhancing the role of nurses and reducing the inappropriate workload of junior hospital doctors.

2. The task for the researchers was the identification of particular working procedures and the measurement and assessment of work activity in a health care setting. The expertise in this area exists in management consultancies as well as in the non-commercial academic sector. Accordingly, three organisations were invited to submit proposals to the Department, two from relevant management consultants and one from the non-commercial academic sector. The successful candidates were the management consultants Greenhalgh and Co which specialises in nursing and health care issues.

3. The project report is expected at the end of 1993.

Q161: *DH Unit Site Visits*

1. The cycle of visits to DH units is not new. Chief Scientists have always visited units once every four years as part of the process of reviewing units' rolling contracts. The reports of these visits are not published and have not been routinely reported to Parliament, but the advice given by the review members is used in decisions to terminate or continue unit contracts.

2. Professor Peckham, since his appointment as Director of Research and Development, has been involved in four review visits. The next is in June of this year and the remainder follow over the course of the next ten months so that all will be completed by the Spring of 1994. The Department is aware that some of the units may wish to participate in the bidding process to become a part or focus of the new research centre and their success in this will influence the decisions to be made at the end of the site visit cycle.

3. The Committee may wish to note that Ministers' intention to launch a pilot research centre for primary health care was announce by Dr Mawhinney in a Parliamentary Question on 25 May. Copies of text of PQ and press release, together with text of the advertisement launching tendering process are set out below as Annex A.

ANNEX A

Written Answer from Official Report Tuesday 25 May 1993

CENTRE FOR RESEARCH AND DEVELOPMENT IN PRIMARY CARE

135 Mr David Evennett (C. Erith and Crayford) To ask the Secretary of State for Health, when she will set up a pilot multidisciplinary based centre for research and development; and if she will make a statement.

DR MAWHINNEY

We have decided to establish a university based research and development centre in the field of primary health care. The increasing importance of this sector means that it is now opportune to develop a capacity to carry out long-term high quality research and development. The delivery of primary care is vital both to the health and well-being of the population and to the effective and efficient delivery of health care services and, increasingly, innovative forms of service delivery and new initiatives in care and treatment are emerging within the sector. Primary care leads the demand for a range of services and, at the present time, is especially significant in inner cities in general and in London in particular. In the coming years, primary care will continue to be a source of exciting developments for the health service.

The establishment of a dedicated long-term research centre will ensure that these developments are linked to research based information, while taking into account likely changes in organization and delivery of care. Both primary care and the programme of research will be defined broadly, to take into account not only the general medical service and general practice but also the flow of patients between primary and secondary care and the nature of the interface between the sectors.

The centre will be established by selective competitive tender from universities in England and Wales. This process will be led by Professor Michael Peckham, the Director of Research and Development. A key consideration in selecting the successful bid will be the extent to which universities show that they can harness a significant contribution to this research field from other funders, including the private sector. Advertisements, and letters to Universities inviting expressions of interest in tendering for the centre, will be published shortly.

Copy of Department of Health Press Release 25th May 1993

MINISTER FOR HEALTH ANNOUNCES MULTI-MILLION POUND INVESTMENT IN PRIMARY CARE RESEARCH AND DEVELOPMENT

Bids invited from English and Welsh universities

A multi-million pound investment in research and development in primary health care was announced today by Dr Brian Mawhinney, Minister for Health.

He said that a university-based Centre for Research and Development in Primary Health Care is to be funded by the Department of Health, at a cost of up to £1.5m a year over ten years.

In a Written Reply to a Parliamentary Question from David Evennett, MP for Erith and Crayford, Waveney, Dr Mawhinney said: "I have decided to establish a university-based research and development centre in the field of primary health care.

"The increasing importance of this sector means that it is now opportune to develop a capacity to carry out long-term, high quality research and development.

"The delivery of primary care is vital both to the health and well-being of the population and to the effective and efficient delivery of health care services and, increasingly, innovative forms of service delivery and new initiatives in care and treatment are merging within this sector.

"Primary care leads the demand for a range of services and, at the present time, is especially significant in inner cities in general and in London in particular. In the coming years, primary care will continue to be a source of exciting developments for the health service.

"The establishment of a dedicated long-term research centre will ensure that these developments are linked to research based information, while taking into account likely changes in organisation and delivery of care. Both primary care and the programme of research will be defined broadly, to take into account not only the general medical service and general practice but also the flow of patients between primary and secondary care and the nature of the interface between the sectors.

"The centre will be established by selective competitive tender from universities in England and Wales. This process will be led by Professor Michael Peckham, the Director of Research and Development.

"A key consideration in selecting the successful bid will be the extent to which universities show that they can harness a significant contribution to this research field from other funders, including the private sector".

Professor Peckham said: "This is an exciting initiative which focuses our research effort on a crucially important aspect of health care. It provides the means of building up a multi-disciplinary team and is a major boost for the health services and related areas of research".

Copy of Department of Health Advertisement

CENTRE FOR RESEARCH AND DEVELOPMENT IN PRIMARY HEALTH CARE

The Department of Health intends to establish a centre for research and development in the field of primary health care. The centre will be set up by selective competitive tender from Universities in England and Wales. Funding from the Department of Health will be up to £1.5m per annum, for a fixed term ten year contract. The main aim of the centre will be to develop and carry out long-term high quality research and development in an area vital to the health of the population and to the effective and efficient delivery of health care.

A full commitment to the Centre will be expected from the university and one key consideration in selecting the successful bid will be the extent to which universities are likely to harness a significant contribution to this research field from other funders, including the private sector.

Universities wishing to express an interest in tendering from the Centre are invited to submit outline proposals to the Department of Health before the end of July 1993. Professor Michael Peckham, the Department's Director of research and Development, has written to Vice-Chancellors with the statement of requirement for the centre. Copies of the requirement and further information can be obtained by writing to Research and Development Division, Department of Health, Skipton House, Room 403A, 80 London Road, Elephant & Castle, London SE1 6LW. Telephone requests to: 071-972 5648 and 972 5641. Fax requests: 972 5666.

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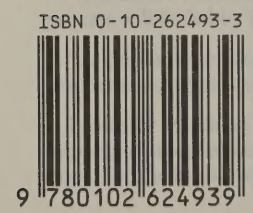

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